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## RECENT DEVELOPMENTS IN KANSAS INSURANCE LAW: A SURVEY, SOME ANALYSIS, AND SOME SUGGESTIONS

*Robert H. Jerry, II\**

In his influential article on insurance law published over two decades ago, Professor Kimball observed that "[i]nsurance is a small world that reflects the purposes of the larger world outside it."<sup>1</sup> We all know well that the "larger world" is becoming increasingly complex. For most of us the "small world" of insurance law, as it reflects and responds to changes in the "larger world," is also becoming increasingly complex. A glimpse at the past illustrates this point. Twenty-five years ago Professor Oldfather's survey of two years of Kansas insurance law filled all of two and one-half pages in the *Kansas Law Review*.<sup>2</sup> He observed that "there were a number of insurance cases" decided during the survey period; he safely claimed that "[s]ome seem to deserve passing reference," and "[o]ne merits more extensive comment."<sup>3</sup> Five years ago, Professor Oldfather's survey of two years of Kansas insurance law filled over thirteen pages in this journal in typeface nearly half the size of that used in 1959.<sup>4</sup> This survey is even longer; obviously, there is more to be said.<sup>5</sup>

This survey has five parts: Part I discusses cases involving questions of contract formation and termination; Part II concerns issues involving the performance of obligations arising out of the insurance contract; Part III studies several cases involving the construction and interpretation of contract language; Part IV is devoted solely to automobile insurance issues; finally, Part V discusses a few detached ideas. "Let us proceed."<sup>6</sup>

### I. CREATING AND TERMINATING INSURANCE CONTRACTS

#### *A. The Duty to Procure Insurance*

An insurance transaction typically involves three parties: the applicant; the insurance company undertaking the risk; and an intermediary between the applicant and the insurance company. The intermediary is sometimes an agent of the insurance company; at other times the intermediary is a broker, who receives a commission from the company for arranging the transaction. If the intermediary undertakes to procure insurance for the applicant and no policy is secured, it

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<sup>1</sup> Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 524 (1961).

<sup>2</sup> Oldfather, *Insurance*, 8 KAN. L. REV. 308 (1959).

<sup>3</sup> *Id.* at 308.

<sup>4</sup> Oldfather, *Survey of Kansas Law: Insurance*, 27 KAN. L. REV. 255 (1979).

<sup>5</sup> The period covered by this survey commences in mid-1980, roughly where the last survey finished, Note, *Survey of Kansas Law: Insurance Law*, 29 KAN. L. REV. 531 (1981), and ends with the May 1983 Advance Sheet of the Kansas Supreme Court.

<sup>6</sup> Oldfather, *supra* n.4, at 255.

often happens that the applicant sues the intermediary for failure to procure insurance. This was the situation in *Marshel Investments, Inc. v. Cohen*.<sup>7</sup>

Plaintiff Marshel Investments (Marshel), acting through its president and principal stockholder Robert Gensch, acquired an oil and gas leasehold interest which included a non-producing well and associated equipment. About a week later, Gensch contacted a Wichita firm of insurance brokers, represented by William Cohen, Sr. Gensch testified that he told Cohen, "Take care of me, Bill. I need complete coverage."<sup>8</sup> Cohen procured two policies from the United States Fidelity and Guaranty Company (USF&G) for Gensch. The policies provided comprehensive general, automobile liability, workmen's compensation, and employer's liability coverage, but they did not provide physical damage coverage for the above-ground equipment or "control of well coverage" for any expenses incurred in extinguishing a fire at the well. Gensch received the policies, but he did not notify Cohen that the issued policies were incomplete. About two weeks later a fire at the well destroyed \$15,000 worth of the above-ground equipment, and expenses of \$35,000 were incurred in extinguishing the blaze.

In Marshel's suit against Cohen and his firm, the jury returned a verdict for plaintiff charging defendant with liability for the value of Marshel's uninsured loss.<sup>9</sup> The trial court set aside this verdict, presumably agreeing with defendant's argument that the agreement between Gensch and Cohen was insufficiently definite to create a duty to procure the insurance.<sup>10</sup> On appeal, the principal issue was what duty, if any, Cohen owed Gensch. Thus, this case raised a troublesome, recurrent question: what is the nature of the obligation owed by the intermediary (either a broker or agent) to the applicant for insurance.

In the bulk of its fifteen-page opinion, the court of appeals summarized in chronological order Kansas cases involving the liability of insurance agents or brokers who had failed to procure or renew insurance.<sup>11</sup> From these cases the court concluded that an insurance agent or broker who undertakes to procure insurance for another owes the applicant what the court labeled "the exercise care duty" (i.e., "the duty to exercise the skill, care and diligence that would be exercised by a reasonably prudent and competent insurance agent or broker acting under the same circumstances").<sup>12</sup> Although this duty resembles the duty of any professional who presents himself to the public as having special skill in the area of his practice, a duty which if breached is actionable in tort,<sup>13</sup> the court explained that "an action for the breach of this [exercise care] duty may be brought in contract *or* in tort."<sup>14</sup> Since no Kansas case had explained the basis for this analysis, the court offered its own: "[T]he duty is both an implied con-

<sup>7</sup> 6 Kan. App. 2d 672, 634 P.2d 133 (1981).

<sup>8</sup> *Id.* at 673, 634 P.2d at 135.

<sup>9</sup> There was some uncertainty regarding how the jury computed the damages. Apparently, the jury awarded Marshel the actual cash value of the above-ground equipment and the fire-fighting costs, less the deductible. The trial judge on his own motion remitted the verdict by an amount he selected for the cost of insurance. Thereafter, the trial judge set aside this remitted verdict. *Id.* at 677, 634 P.2d at 137.

<sup>10</sup> This was the position taken by defendant's counsel at the post-trial hearing. When setting aside the verdict, the trial judge "expressed uncertainty as to the state of Kansas law applicable to the case and, when sustaining Cohen's motion, commented his decision was substantially a choice of which party would be the moving party on appeal." *Id.* at 677, 634 P.2d at 137.

<sup>11</sup> *Id.* at 677-83, 634 P.2d at 138-41.

<sup>12</sup> *Id.* at 683, 634 P.2d at 141.

<sup>13</sup> See *Malone v. University of Kansas Medical Center*, 220 Kan. 371, 375, 552 P.2d 885, 888 (1976).

<sup>14</sup> 6 Kan. App. 2d at 683, 634 P.2d at 141 (emphasis added).

tractual term of the undertaking (contract duty) and a part of the fiduciary duty owed the client by reason of the principal-agent relationship arising out of the undertaking (tort duty)."<sup>15</sup> The court observed that the cause of action was not one for "negligent breach of contract,"<sup>16</sup> since contract liability is no-fault liability: "if there is a breach of contract, there is a breach of contract whether because of intentional conduct, inability to perform, accident, negligence, or whatever."<sup>17</sup> After articulating the exercise care duty, the court was unable to conclude that as a matter of law Cohen did not owe it.<sup>18</sup> Because the jury could have concluded on the evidence that the duty had been breached, the court held that the trial judge erred in setting aside the jury verdict.<sup>19</sup>

The court of appeals in *Marshel Investments* reaffirmed, as it should have, the general principle that one who undertakes to procure insurance for another and thereafter fails to do so is responsible for resulting damages.<sup>20</sup> There is nothing in the facts of *Marshel Investments*, as reported by the court, to suggest that the court erred in refusing to find that defendant had no duty to plaintiff as a matter of law. Yet the court's rationale for this result, including its articulation of the "exercise care duty," is not entirely satisfying. This is not to disparage the court's opinion, for courts throughout the country find this a difficult issue.

Actually, most failure to procure insurance cases are breach of contract cases. Disposing of these cases under tort law principles is rarely advantageous to the plaintiff and is sometimes unprincipled.

When the intermediary fails to secure insurance for the applicant, there is usually a bilateral contract between the applicant and the intermediary. The intermediary promises to procure a policy of insurance for the applicant. The consideration for the intermediary's promise is the applicant's promise to pay premiums, and the consideration for the applicant's promise is the intermediary's performance.<sup>21</sup> Thus the intermediary's nonperformance is a breach of this bilateral contract. Even in the unlikely event that the applicant makes no promise to pay premiums, thereby failing to provide a consideration to support the intermediary's promise, the intermediary's promise to procure an insurance policy may nevertheless be enforceable under the doctrine of promissory estoppel.<sup>22</sup>

<sup>15</sup> *Id.*

<sup>16</sup> Some courts, most notably California courts, have endorsed this odd theory. *E.g.*, *Jackson v. Aetna Life & Casualty Co.*, 93 Cal. App. 3d 838, 155 Cal. Rptr. 905 (1979).

<sup>17</sup> 6 Kan. App. 2d at 683, 634 P.2d at 142.

<sup>18</sup> *Id.* at 685, 634 P.2d at 143.

<sup>19</sup> *Id.* at 686, 634 P.2d at 143.

<sup>20</sup> This principle has a firm basis in Kansas decisions. *See, e.g.*, *Marker v. Preferred Fire Ins. Co.*, 211 Kan. 427, 431, 506 P.2d 1163, 1168 (1973).

<sup>21</sup> In *Marker*, *supra* note 20, the supreme court described the consideration for the broker's promise to procure insurance as "the expectation of the broker of receiving a commission or profit when the insurance policy is obtained." 211 Kan. at 432, 506 P.2d at 1168. The analysis is unsound, because the commission or profit is not given by the applicant in exchange for the broker's promise to secure the insurance. *See* RESTATEMENT (SECOND) OF CONTRACTS § 71(2) (1981). The applicant's promise to pay premiums is what the broker bargains for, and the applicant gives this promise in exchange for the broker's promise. The fact that the applicant's performance is promised to a third party, that is, the insurance company, does not prevent the applicant's promise from serving as consideration for the broker's promise. *Id.*, § 71(4).

<sup>22</sup> Under the doctrine of promissory estoppel, a promise which the promisor should reasonably expect to induce forbearance on the part of the promisee and which does induce such forbearance is binding if injustice can be avoided only by enforcing the promise. *Berryman v. Kmoch*, 221 Kan. 304, 307, 559 P.2d 790, 794 (1977). At the least, the intermediary is likely to make a promise to procure insurance. The intermediary should reasonably expect the promisee to refrain from seeking insurance elsewhere, and if

These contract principles should be adequate to dispose of most failure to procure insurance cases fairly. Indeed, in few cases will asserting the claim in tort yield significant advantages for the plaintiff. The statute of limitations for tort actions is shorter.<sup>23</sup> More importantly, to establish a breach of the duty in tort, the plaintiff must prove negligence by demonstrating that the intermediary failed to act as a reasonable intermediary would have in the same circumstances. Such a showing is not required under the contract theory; the plaintiff need only show an enforceable promise and its non-performance.

It is true that the plaintiff in tort has a wider array of damage remedies, such as damages for emotional distress and punitive damages. However, rarely will reimbursing the pecuniary loss caused by the intermediary's failure to procure insurance not be a complete remedy. If the intermediary commits fraud, or if the intermediary's conduct is an "outrage,"<sup>24</sup> a separate action in tort exists, for which the broader tort remedies are available. Also, the supreme court's latest decisions have limited the insured's recovery in an action against the insurer to contract damages.<sup>25</sup> There is no compelling reason to make available a broader range of damages to the plaintiff suing for failure to secure the insurance contract than to a plaintiff suing on the contract itself. If there are cases where the intermediary's conduct somehow falls short of constituting a tort but is nonetheless so egregious that society has a legitimate interest in deterring that conduct, perhaps the best solution would be to loosen slightly the standard for awarding punitive damages in contract actions.<sup>26</sup>

Beyond the fact that aggrieved applicants should not realize any significant benefit from suing in tort instead of in contract, the tort theory is often asserted in an unprincipled manner. As explained by the court of appeals, the tort claim is premised on the intermediary's breach of a fiduciary duty owed the applicant that arises out of a principal-agent relationship.<sup>27</sup> Rarely is the intermediary the applicant's agent. Unless there is a right to control, no agency relationship exists.<sup>28</sup> Demanding a particular result from the intermediary does not mean that the applicant has the right to control the intermediary's activities. Moreover, when the intermediary is an employed "agent" of the insurance company instead of a broker, declaring that the intermediary is the applicant's agent violates the general principle that a person cannot serve simultaneously as the agent of two adverse parties without the informed consent of both, which is rarely the case in

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this reliance occurs and the promisee suffers a loss thereby, the intermediary's promise should be enforced notwithstanding the absence of a consideration. *See* RESTATEMENT (SECOND) OF CONTRACTS §§ 17, 90 (1981).

<sup>23</sup> For a breach of an oral contract, the statute of limitations is three years; for negligence, the statute of limitations is two years. KAN. STAT. ANN. 60-512, 60-513 (1976).

<sup>24</sup> To state a claim in tort for "outrage," the plaintiff must establish (1) that the defendant's conduct was intentional or in reckless disregard of the plaintiff; (2) that the defendant's conduct was extreme and outrageous; (3) a causal connection between defendant's conduct and plaintiff's mental distress; and (4) extreme and severe mental distress on the part of the plaintiff. *Roberts v. Saylor*, 230 Kan. 289, 292, 637 P.2d 1175, 1179 (1981).

<sup>25</sup> *See* *Guarantee Abstract & Title Co. v. Interstate Fire & Cas. Co.*, 232 Kan. 76, 652 P.2d 665 (1982), discussed *infra* at notes 96-112 and accompanying text.

<sup>26</sup> This suggestion is also made elsewhere in this article. *See infra* notes 131-33 and accompanying text. However, concerning failure to procure insurance, it would be premature to conclude that the standard for awarding punitive damages in contract should be loosened before some experience develops with the exclusive use of contract remedies in this context.

<sup>27</sup> 6 Kan. App. 2d at 683, 634 P.2d at 142.

<sup>28</sup> *W. SEAVEY, AGENCY* § 3, at 3 (1964).

an insurance transaction.<sup>29</sup> Kansas courts, when confronted with this problem, concluded that an insurance agent may serve as a dual agent in some situations.<sup>30</sup> This exception to the rules of agency would not be necessary if the failure to procure insurance were treated as a breach of contract, rather than as a tort.

Of course, it might be argued that an individual who is injured by the failure of the intermediary to procure insurance has a claim in tort because the intermediary has committed professional malpractice, traditionally treated as a tort action. Whether claims for professional malpractice actually sound in contract or in tort is debatable.<sup>31</sup> I will not attempt to resolve that issue here. Nevertheless, if applicants who never receive policies because of an act or omission of the intermediary are deemed to have a claim in tort because the intermediary's failure is "professional malpractice," it probably would not be long before anyone who did not receive services promised by another, or anyone who received improperly performed services, would have a claim in tort.

### B. Group Insurance

*Estate of Bingham v. Nationwide Life Insurance Co.*,<sup>32</sup> decided by the court of appeals and affirmed per curiam by the supreme court, has important implications for group insurance marketing.

Clifford Bingham was employed by Merriam Motors continuously since 1964. Merriam's president arranged for group health and life insurance for the employees, sometimes changing insurers if better coverage or a lower premium became available. When a policy with Capital Life Insurance Company was about to expire, the president, encouraged by a broker, arranged for a Nationwide policy providing the same coverage to replace the Capital Life policy. The president expected the new Nationwide policy to continue the coverage previously provided by Capital Life.<sup>33</sup>

Bingham had a heart attack on August 24, 1977, and was hospitalized until September 27. Until October 26, when he started spending part-days at the office, he recuperated at home, "occasionally" taking phone calls from the office. During the period Bingham was recuperating at home, a card enrolling him in the Nationwide group was signed on his behalf.<sup>34</sup> On November 7, Bingham signed a "Supplemental Enrollment Card," which Nationwide required from all managerial employees, on which he represented that on the date of signature he was "actively at work . . . on a full-time basis."<sup>35</sup> Bingham also represented on the card that he worked "at least the number of hours in [his] employer's normal work week, but not less than 30 hours per week . . .," and that "[d]uring the

<sup>29</sup> R. KEETON, *INSURANCE LAW* 58 (1971).

<sup>30</sup> 6 Kan. App. 2d at 682, 634 P.2d at 143; *Stamps v. Consolidated Underwriters*, 205 Kan. 187, 197, 468 P.2d 84, 92 (1970).

<sup>31</sup> See Jerry, *Recovery in Tort for Educational Malpractice: Problems of Theory and Policy*, 29 KAN. L. REV. 195 n.2 (1981); O'Connell, *The Interlocking Death and Rebirth of Contract and Tort*, 75 U. MICH. L. REV. 659, 665-66 (1977) (discussing, but rejecting argument that contract theory in allocating loss in medical malpractice is solution to tort law's deficiencies).

<sup>32</sup> 7 Kan. App. 2d 72, 638 P.2d 352, *aff'd per curiam, as modified*, 231 Kan. 389, 646 P.2d 1048 (1982).

<sup>33</sup> 7 Kan. App. 2d at 74, 638 P.2d at 354.

<sup>34</sup> *Estate of Bingham v. Nationwide Life Ins. Co.* at ¶ 2f (Dist. Ct. Johnson County May 13, 1980) (mem.), *reprinted in* Brief for Appellant, at 36.

<sup>35</sup> 7 Kan. App. 2d at 76, 638 P.2d at 356.

past four weeks" he had "not been absent from work on account of [his] own sickness or injury."<sup>36</sup> On November 16, Bingham suffered a fatal heart attack.

The broker who helped arrange the transaction knew about Bingham's heart problem and his absence from work, but there was no evidence that Nationwide received this information. Nationwide refused to pay the proceeds of the policy to Bingham's beneficiaries, and litigation followed. The trial court entered a judgment against Nationwide, concluding first, that Bingham was covered by the policy at the time of his death in that he was "regularly employed" at the time the policy went into effect, and second, that Bingham's misrepresentations on the Supplemental Enrollment Card did not void the coverage.<sup>37</sup> On appeal, Nationwide disputed both conclusions.<sup>38</sup> The court of appeals affirmed the trial court, and the supreme court in a per curiam opinion adopted the court of appeals opinion as its own.<sup>39</sup>

In the first part of its opinion, the court of appeals agreed that Bingham was a full-time employee working thirty hours a week and was therefore a covered employee as of November 1, 1977, the effective date of the Nationwide policy.<sup>40</sup> This conclusion is troublesome. It is true, as the court stated, that "active and full-time employment" does not necessarily mean regular or continuous employment at a particular place.<sup>41</sup> However, the Nationwide policy defined an eligible person as one who "on the effective date of this Policy, is regularly employed" or who, "subsequent to the effective date of this Policy, has been regularly employed . . . not less than one month."<sup>42</sup> Further, being "regularly employed" was defined as being "continuously employed by the Policyholder for at least 30 hours each week."<sup>43</sup> On November 1, 1977, Bingham had only been working half-days for five days and had only "occasionally" performed work during the preceding two months of hospitalization and home recuperation. Moreover, Bingham worked only nine full days prior to his death, so it could not be said that Bingham was regularly employed for "not less than one month."

The court overcame these difficulties by reasoning that the policy's requirement that the employee be continuously employed at least thirty hours a week as of the policy's effective date was intended only to exclude part-time employees.<sup>44</sup> Thus, by this logic, Bingham was a full-time, "regularly employed" employee, who was temporarily ill from August 24 to November 7, and who resumed his regular work schedule nine days before his death. So viewed, Bingham was an "eligible person" covered by the policy on November 1, since he was not a part-time employee on that date.

While one purpose of the continuous employment requirement was to exclude part-time employees, the court overlooked another important purpose. Insurers

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<sup>36</sup> *Id.*

<sup>37</sup> *Estate of Bingham* (mem.), *supra* note 34, at ¶¶ 3b, 4.

<sup>38</sup> The trial court also awarded attorneys' fees to plaintiffs under KAN. STAT. ANN. § 40-256 (1981). 7 Kan. App. 2d at 73, 638 P.2d at 353. This was also disputed by Nationwide on appeal, and the award was affirmed by both the court of appeals and the supreme court. *Id.*

<sup>39</sup> 231 Kan. 389, 646 P.2d 1048 (1982).

<sup>40</sup> 7 Kan. App. 2d at 79, 638 P.2d at 358.

<sup>41</sup> *Id.* at 78, 638 P.2d at 357, quoting 1 APPLEMAN, INSURANCE LAW AND PRACTICE, § 44, n.13.15, at 75 (1980 Supp.).

<sup>42</sup> Brief for Appellant at 31, *Estate of Bingham* (mem.), *supra* note 34.

<sup>43</sup> 7 Kan. App. 2d at 76, 638 P.2d at 355.

<sup>44</sup> *Id.* at 79, 638 P.2d at 357.

offer life insurance, whether group or individual, to persons who meet specific eligibility requirements. These requirements are part of the terms on which the insurer offers the group policy.<sup>45</sup> Requirements typically found in group insurance policies that employees be active or full-time employees on the policy's effective date are intended as a substitute for detailed underwriting. It is reasonable to believe that a person working on the policy's effective date is probably in good health.<sup>46</sup> An employee who is so ill that he cannot work on the policy's effective date has a characteristic highly relevant to the risk.<sup>47</sup> Nationwide was only willing to insure an employee who was regularly employed on the effective date, or who, if unable to work on the effective date due to a disability preventing him from working at least thirty hours a week on a "continuous" basis,<sup>48</sup> demonstrated his health by working a continuous month. In other cases raising this problem, courts have been sympathetic to those with a temporary illness on the policy's effective date, but courts have also found employees possessing a serious illness on the effective date to be ineligible for group insurance.<sup>49</sup> Although Nationwide's policy could have been drafted more precisely, its underwriting objective, which is apparent from viewing the policy as a whole, is not unreasonable.

In spite of these weaknesses in the court's analysis, the court, based on the facts reported in the opinion, reached the correct result. It is critical that Nationwide's policy was sold to replace existing coverages under the Capital Life policy. If the Nationwide policy had been the first policy purchased by Merriam Motors for its employees, a strong argument exists that Bingham was not a covered employee. However, in group insurance, "ordinarily a second [successor] insurer takes over the rights and obligations of the first company as they exist upon the date of its succession . . . . If this were not true, an employer and various companies could play games with the employees and nullify the rights of those depending upon such protection, by simply shuffling the contracts from one company to another."<sup>50</sup>

Bingham's employer, who was the policyholder, reasonably expected that full coverage would continue when Nationwide succeeded Capital Life as the insurer. Nationwide argued that it did not know of Bingham's illness, but the more important fact is that Bingham's employer did not know that Nationwide would not cover Bingham. It is probable that if Nationwide had informed Bingham's employer that it would not insure anyone with an existing illness (Bingham was at home recuperating when the transaction was completed), Bingham's employer would not have changed insurers. Thus, the court might have decided this case by holding that Nationwide was estopped to deny that Bingham was a covered employee, having sold the policy to Bingham's employer by creating or permit-

<sup>45</sup> 1 APPLEMAN, *supra* note 41, § 44, at 120 (1981).

<sup>46</sup> *Id.* at 131. See *Mannschreck v. Connecticut Gen. Life Ins. Co.*, 200 Neb. 434, 263 N.W.2d 849, 851-53 (1978).

<sup>47</sup> 1 APPLEMAN, *supra* note 41, § 44, at 120.

<sup>48</sup> What "continuous" means in this context is also subject to dispute. Is an employee who misses two eight-hour work days in one week three weeks ago "continuously" employed on the effective date? See Brief for Appellee at 10, *Estate of Bingham* (mem.), *supra* note 34. Apparently not: such an employee must work for one more week after the effective date so as to have been regularly employed for not less than one month. The effective date of coverage for that employee would be one week after the policy's effective date.

<sup>49</sup> See 1 APPLEMAN, *supra* note 41, § 44, at 136-40.

<sup>50</sup> *Id.*, § 46, at 165-66 (citation omitted).



ting the reasonable expectation that coverage for all employees protected by the Capital Life policy would continue under the Nationwide policy. If this case had been decided on this narrower ground, strained construction of the policy's language would not have been necessary.

Taking a narrower approach to this case would also have avoided the difficulties with the court's treatment of the second issue in the case concerning Bingham's misrepresentations on the Supplemental Enrollment Card. The representations that Bingham made when affixing his signature to the Card were false. These representations were material to the risk being undertaken by Nationwide; thus, the fact that the "Supplemental Enrollment Card was not a warranty"<sup>51</sup> was irrelevant. The court also relied on section 434 of title 40 of the Kansas Statutes, which requires the group policy to state "the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage."<sup>52</sup> The court said that the "taking of the card violated the spirit," if not the language of this statute, because "the policy contained no conditions setting forth a reservation of the right to require such cards."<sup>53</sup> The court's logic is unclear, since the policy did state that eligibility depended on being regularly employed on the effective date or for a one-month period ending subsequent to the effective date. The Supplemental Enrollment Card merely asked each managerial employee to represent his eligibility, according to the policy's standards. Section 434 does not prohibit an insurer from setting underwriting standards in group insurance that disqualify some members of a broader designated class, and Nationwide's procedures seemed to do no more than this.

Had the court treated this case as a "successive insurer" case, the misrepresentation issue would have been resolved easily. The misrepresentations on the Card would have been immaterial. If Nationwide assumed the obligations of Capital Life, there was no need whatever for the Supplemental Enrollment Card.

The court of appeals did not base its decision on Nationwide's failure to advise the policyholder that coverage for all previously protected employees would not necessarily continue under the new insurer's policy. Instead, the court based its decision on two grounds that have the potential to limit legitimate risk avoidance by insurers marketing group policies.<sup>54</sup> Only if future cases do not extend the holding in *Estate of Bingham* beyond the facts of that case will adverse effects on group insurance marketing be prevented. Regardless, *Estate of Bingham* warns insurers seeking to acquire already underwritten groups to disclose fully the possible gaps in coverage caused by changing insurance companies.

### *C. Termination: The Effect of Grace Periods*

Just as it is important to determine when coverage begins, it is likewise important to determine when coverage ends. In *Bennett v. Colonial Life & Accident Insurance Co.*,<sup>55</sup> the court of appeals discussed the circumstances under which a

<sup>51</sup> See 7 Kan. App. 2d at 79, 638 P.2d at 358.

<sup>52</sup> KAN. STAT. ANN. § 40-434(4) (Supp. 1980).

<sup>53</sup> 7 Kan. App. 2d at 80, 638 P.2d at 358.

<sup>54</sup> See *supra* text accompanying notes 45-49.

<sup>55</sup> 7 Kan. App. 2d 441, 643 P.2d 1133 (1982).

standard grace period provision in a life insurance policy extends the policy's termination date.

Colonial Life insured Michael Bennett under an insurance policy obtained through his employer, with premiums paid by payroll deduction. Bennett subsequently communicated to his employer his desire to cancel his insurance. The employer deleted Bennett's name from the current invoice and returned the invoice to Colonial without a payment for Bennett. Upon receipt of this invoice, Colonial cancelled Bennett's policy. Bennett died two days after the cancellation. Plaintiff, the designated beneficiary of the policy, claimed that Bennett's life was insured at his death because of the thirty-one day grace period for the premium payment. The trial court entered a summary judgment for plaintiff.

On appeal, the court held first that the policy was cancelled by mutual consent.<sup>56</sup> In the next part of its opinion, the court reasoned that the grace period's "sole purpose . . . is to prevent immediate lapse upon failure to pay a premium."<sup>57</sup> Therefore, the court correctly ruled, the grace period does not extend coverage when the policy expires by its own terms or is terminated by mutual consent of the parties. The summary judgment for plaintiff was reversed, and judgment was entered for Colonial.<sup>58</sup> This result is firmly grounded in basic contract principles. While the expectations of the beneficiary-plaintiff might have been disappointed, the expectations of the owner of a life insurance policy are usually overriding.<sup>59</sup> In *Bennett*, the reasonable expectations of the owner of the policy were realized.

## II. CONTRACT PERFORMANCE

### A. *The Duty to Defend, the Duty to Settle, and the Duty to Appeal Adverse Judgments*

#### 1. *General Principles*

Two questions have spawned a mass of confusing and contradictory court decisions nationwide. The first question concerns the scope of the insurer's duties to defend and settle claims made against its insured and to appeal adverse judgments; the second involves the nature of the remedy for a breach of these duties. A recent annotation on one issue devolving from these questions illustrates the diversity of approaches to their resolution.<sup>60</sup>

All modern liability policies contain a provision requiring the insurer to defend any suit brought against an insured alleging bodily injury or property damage covered by the policy, even if the suit is "groundless, false or fraudulent."<sup>61</sup> Since this undertaking is part of the insurer's express agreement, a claim that the duty to defend has been breached is a contract claim. The insurer's duty comes into existence as soon as the insurance contract is formed, but the insurer's per-

<sup>56</sup> *Id.* at 443, 643 P.2d at 1136.

<sup>57</sup> *Id.*

<sup>58</sup> *Id.* at 444, 643 P.2d at 1136.

<sup>59</sup> See R. KEETON, *supra* note 29, at 253-57.

<sup>60</sup> Annot., 20 A.L.R.4th 23 (1983).

<sup>61</sup> For example, the Lawyer's Professional Liability Insurance Policy, sold by Lawyers' Mutual Insurance Company, states in the first paragraph of section two under the heading "The Coverage": "The Company agrees, with respect to any claim seeking damages for which the Company is obligated to indemnify the insured, to defend such suit even if any or all of the allegations of the suit are groundless, false or fraudulent." Reprinted in K. YORK & J. WHELAN, *INSURANCE LAW: CASES, MATERIALS, AND PROBLEMS* 697 (1982).

formance of its duty is not due until a lawsuit is filed against the insured. Thus, the insurer's duty is a conditional one: the insurer agrees to undertake the defense of the insured upon the occurrence of an event in the future (i.e., a lawsuit), which may or may not occur.<sup>62</sup>

It is now firmly established as a principle of insurance law that the insurer also owes the insured a duty regarding settlement of the claim asserted against him. Unlike the related duty to defend, the source of the duty to settle is not obvious. For example, the language of a typical liability policy does not require the insurer to settle lawsuits but merely gives the insurer the privilege of settling the claim or suit "as it deems expedient."<sup>63</sup> Accordingly, the prevailing view in most jurisdictions is that the duty to settle is imposed by law, not by the express agreement of the parties, and therefore a suit for breach of the duty to settle lies in tort.<sup>64</sup> However, a few jurisdictions—and now, as discussed below, Kansas—treat the duty as sounding in contract.<sup>65</sup>

Closely related to the duties to defend and settle is the duty of the insurer to participate in appeals from trial court judgments involving its insured. Although the ordinary liability policy does not contain language explicitly creating a duty to appeal adverse judgments, it is nonetheless widely thought that the duty to appeal is part of the duty to defend. Plainly, the insurer's obligation to defend the suit is not fulfilled when a successful result is achieved in the trial court; rather, the insurer is obligated to defend any appeal the claimant might pursue. Similarly, the insurer whose trial court defense is unsuccessful has not discharged its duty to defend, but must undertake an appeal when it appears that "the substantial interests of the insured may be served."<sup>66</sup>

During the survey period, Kansas courts decided cases involving each of the foregoing duties. The decisions are significant because they articulate the standards of care required to fulfill the duties and prescribe the measure of damages in the event the duties are breached.

## 2. *An Easy Case: Casualty Reciprocal Exchange*

During the survey period, the court of appeals decided one case involving the duty to defend that was relatively straightforward. In *Casualty Reciprocal Exchange v. Thomas*,<sup>67</sup> the insurer sought a declaratory judgment concerning its duties to its insured under a policy of homeowner's insurance. The insured was a defendant in an action brought by a third party who was injured by a bullet shot from a handgun held, aimed, and fired at him by the insured. The trial court held that the victim's injuries were intentionally caused by the insured. Because the policy did not cover liability for bodily injury caused to third persons that "is either expected or intended from the standpoint of the Insured," the trial court concluded that the insurer had no duty to defend or indemnify its insured. The injured third party appealed.

The court of appeals began by noting the rule, followed in Kansas and most

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<sup>62</sup> See RESTATEMENT (SECOND) OF CONTRACTS § 224 (1981).

<sup>63</sup> See policy described in note 61, *supra*, reprinted in YORK & WHELAN, *supra* note 61, at 697.

<sup>64</sup> R. KEETON, *supra* note 29, at 508-09.

<sup>65</sup> See cases cited in A. WINDT, INSURANCE CLAIMS AND DISPUTES 205 n.82 (1982).

<sup>66</sup> 7C. APPELMAN § 4688, at 200-01 (1979).

<sup>67</sup> 7 Kan. App. 2d 718, 647 P.2d 1361 (1982).

other jurisdictions, that the insured has a duty to defend if there is a possibility of coverage under a policy based on all information known or reasonably ascertainable by the insured; however, if there is no coverage, there is no duty to defend.<sup>68</sup> The court affirmed the trial court's findings that appellant's injuries were intentionally caused by Thomas.<sup>69</sup> Thus, under the facts of the case, there was no coverage under the policy, and hence no duty to defend.<sup>70</sup>

The other Kansas cases were much more difficult.

### 3. *Hard Cases: The Guarantee Abstract and Title Litigation*

#### a. *A Summary of the Cases*

*Guarantee Abstract and Title Co., Inc. v. Interstate Fire and Casualty Co.*, [*Guarantee I*],<sup>71</sup> was itself a subsequent round in litigation from an earlier period. In *Ford v. Guarantee Abstract and Title Co.*,<sup>72</sup> Guarantee and its principal Chicago Title Insurance Company (Chicago Title) were found liable to the plaintiff for the negligent and reckless acts of a Guarantee officer in a real estate transaction.<sup>73</sup> Both compensatory and punitive damages were assessed against Guarantee and Chicago Title. After these judgments were satisfied, Guarantee, which had indemnified Chicago Title, sued Interstate, its insurer. Guarantee claimed in count I that Interstate was obligated to reimburse Guarantee for all actual and punitive damages awarded in *Ford*. In count II, Guarantee charged that Interstate was guilty of negligence and bad faith in its defense of Guarantee in the prior action. The trial court directed verdicts for Guarantee on count I and for Interstate on count II.

Interstate appealed that portion of the trial court's judgment requiring it to reimburse Guarantee for its punitive damages liability. The trial court had reasoned that Kansas appellate courts would create an exception to the rule prohibiting insurance coverage for punitive damages.<sup>74</sup> Some courts in other jurisdictions have held that public policy does not prohibit purchasing insurance against vicarious liability for punitive damages arising out of the actions of the insured's servant, agent, or employee.<sup>75</sup> The supreme court not only disagreed with the trial court's decision that this was a case of vicarious liability, but the court also rejected the vicarious liability exception to the rule prohibiting insurance coverage for punitive damages.<sup>76</sup>

<sup>68</sup> *Id.* at 720, 647 P.2d at 1363.

<sup>69</sup> The victim argued that there was no evidence that the insured intended to injure him, relying on *Spruill Motors, Inc. v. Universal Underwriters Ins. Co.*, 212 Kan. 681, 512 P.2d 403 (1973). The court, however, distinguished *Spruill* on its facts. 7 Kan. App. 2d at 720-21, 647 P.2d at 1363-64.

<sup>70</sup> 7 Kan. App. 2d at 721, 647 P.2d at 1364.

<sup>71</sup> 228 Kan. 532, 618 P.2d 1195 (1980).

<sup>72</sup> 220 Kan. 244, 553 P.2d 254 (1976).

<sup>73</sup> Presumably spurred by the *Guarantee Abstract and Title* litigation, the legislature enacted in 1983 a statute prohibiting the writing of title insurance "unless and until the insurance company or its agent has caused to be conducted a reasonable search and examination of the title to the property involved and caused to be made a determination of insurability of title and the risk in accordance with sound underwriting practices." Act of April 11, 1983, ch. 154, § 1(b), 1983 Kan. Sess. Laws 830, 831.

<sup>74</sup> In *Koch v. Merchants Mutual Bonding Co.*, 211 Kan. 397, 405, 507 P.2d 189, 196 (1973), the supreme court held that public policy does not permit a tortfeasor to purchase insurance to cover punitive damages. As the court acknowledged in *Koch*, "there is considerable diversity of opinion" among the jurisdictions that have addressed the question of whether punitive damage liability is insurable. *Id.*

<sup>75</sup> See Annot., 16 A.L.R. 4th 11, 25-27 (1982).

<sup>76</sup> 228 Kan. at 535, 618 P.2d at 1198.

Guarantee, in its cross-appeal, challenged the directed verdict for Interstate on count II. Guarantee argued, among other things, that Interstate knew Ford's lawsuit could be settled for a relatively small amount and failed to act on that knowledge, and that Interstate acted in bad faith by refusing to appeal the judgment in *Ford* against Guarantee.

On the issue of Interstate's failure to settle, the court began by reiterating its earlier holding in *Bollinger v. Nuss*,<sup>77</sup> in which it recognized the insurer's duty to its insured in settlement and defense. Under the rule of *Bollinger*, once an insurer assumes control of the right of settlement, the insurer is liable to the insured for any loss in excess of the policy's limits if the insurer fails to exercise good faith. The source of this duty is public policy, which "dictates that the insured's interests be adequately protected. . . . [T]his may be best accomplished by holding that both due care and good faith are required of the insurer in reaching the decision not to settle."<sup>78</sup> Under these circumstances, the court explained, "plaintiff Guarantee could have a good cause of action against Interstate in its tort action."<sup>79</sup> Thus, in *Guarantee I*, the supreme court assumed that the action brought by the insured against the insurer for breach of the duty to settle sounded in tort. The court ordered the jury upon remand to determine whether Interstate had a duty to settle and, if so, the damages for breach of the duty.<sup>80</sup>

On the issue of the insurer's duty to undertake an appeal on behalf of the insured, a question of first impression in Kansas, the court adopted the rule followed in most jurisdictions: the duty to defend does not necessarily obligate the insurer to prosecute an appeal on the insured's behalf, even if a judgment has been rendered against the insured in excess of policy limits.<sup>81</sup> The test approved by the court was whether the insurer exercised "good faith and fair dealing . . . judged in the light of the rights of the insured as well as those of the insurer."<sup>82</sup> The court, in applying this rule to the situation in *Guarantee I*, said "we do not look with favor upon an insurance company that abandons its insured and refuses to appeal, relying on its immunity from a claim for punitive damages."<sup>83</sup> Accordingly, the court affirmed the trial court's finding that Interstate should have appealed on behalf of Guarantee, and remanded the case for determination of damages without giving guidance on how the damages were to be computed.<sup>84</sup>

Between the decision in *Guarantee I* and the appeal from the judgment in the remanded proceedings, the supreme court issued its opinion in *Spencer v. Aetna Life & Casualty Insurance Co.*<sup>85</sup> *Spencer* was decided pursuant to certification from the United States District Court. In the federal court action, plaintiff alleged that her insurer had committed the tort of "bad faith" in failing to pay her the proper amount of proceeds under a policy insuring her rental properties against loss by fire. The federal district court certified the question of whether Kansas law rec-

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<sup>77</sup> 202 Kan. 326, 449 P.2d 502 (1969).

<sup>78</sup> *Id.* at 333, 449 P.2d at 508.

<sup>79</sup> 228 Kan. at 537, 618 P.2d at 1199 (emphasis added).

<sup>80</sup> *Id.* at 539, 618 P.2d at 1201.

<sup>81</sup> *Id.* at 538, 618 P.2d at 1200.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.* at 539, 618 P.2d at 1200.

<sup>84</sup> *Id.*

<sup>85</sup> 227 Kan. 914, 611 P.2d 149 (1980).

ognizes the tort of "bad faith."<sup>86</sup>

After quoting at length from *Bollinger v. Nuss*,<sup>87</sup> the court stated in *Spencer* that, while it is clear that the insurer owes the insured the duty to act in good faith and without negligence in defending and settling claims against the insured (the so-called "third-party" situation), neither *Bollinger* nor other Kansas cases had "gone so far as to find that the lack of good faith by an insurer in dealings on behalf of his insured rises to the level of an independent tort."<sup>88</sup> In this passage the court seemed to stop short, albeit barely so, of stating definitively that bad faith or negligence in the third-party situation is not a tort. That the court meant to limit its ensuing discussion in *Spencer* to first-party situations was again suggested in the opinion's next paragraph: the court explained that the first-party situation, in which an insured seeks reimbursement from an insurer for damage to his own property, materially differs from the third-party situation. The court said that in the third-party situation the insurer is a fiduciary for the insured, whereas there is no fiduciary relationship in the adversarial first-party situation.<sup>89</sup>

Immediately after drawing this distinction, the court in *Spencer* announced that it was "[t]urning to the question of the existence of a bad faith tort in *first party situations*."<sup>90</sup> By phrasing the issue in this way, the court seemingly eschewed announcing a rule for third-party situations. The remainder of the court's opinion was devoted to answering the question as posited. The court reasoned that the existence of a bad faith tort in first-party situations turned on "whether there are wrongs being committed by insurance companies against their insureds for which there is no adequate remedy under present law."<sup>91</sup> To answer this question, the court examined the "remedies provided by statute."<sup>92</sup> After a lengthy description of various statutes regulating insurance companies and providing for the recovery of attorney fees,<sup>93</sup> the court stated that "in the absence of a more definitive showing of inadequacy of the remedy than we have before us at this time, we hold the [statutory] remedies are adequate to force compliance with the terms of insurance contracts."<sup>94</sup> In the final sentence of the opinion, when the court restated its holding as "the tort of bad faith is not recognized in Kansas,"<sup>95</sup> the court gave no indication that the holding was limited to first-party situations specifically, or to insurance contracts generally.

Thus, after *Spencer*, there was clearly no tort of bad faith in first-party insurance situations. Whether the court in *Spencer* meant to include third-party situations within the scope of its holding was uncertain, however. The court in *Spencer* provided no explanation for treating the breach of the duty of good faith and fair dealing in the fiduciary third-party setting as something other than tort, and the

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<sup>86</sup> *Id.*

<sup>87</sup> 202 Kan. 326, 449 P.2d 502 (1969).

<sup>88</sup> 227 Kan. at 922, 611 P.2d at 155.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.* (emphasis added).

<sup>91</sup> 227 Kan. at 922-23, 611 P.2d at 155.

<sup>92</sup> 227 Kan. at 923, 611 P.2d at 156.

<sup>93</sup> 227 Kan. at 923-26, 611 P.2d at 156-58.

<sup>94</sup> 227 Kan. at 926, 611 P.2d at 158.

<sup>95</sup> *Id.*

court's earlier opinion in *Guarantee I* had described the third-party claim as being in tort. Yet in *Spencer* the court broadly stated that there was no tort of bad faith.

Against this confused background the court considered in *Guarantee II* Interstate's appeal of the judgment on remand from *Guarantee I*. Upon remand, the jury concluded that Interstate had breached its duty to settle. Compensatory damages of nearly \$70,000 as well as punitive damages of \$100,000 were awarded on this count. As for the refusal to appeal, compensatory damages of approximately \$7,000 and punitive damages of \$150,000 were assessed against Interstate.

In *Guarantee II*,<sup>96</sup> the court reversed the award of punitive damages on the ground that both the duty to settle and the duty to appeal, if any, arise from the insurer's express contractual undertaking to defend any suit filed against the insured. Thus, a claim that the duty to settle or appeal has been breached sounds in contract. Punitive damages may not be awarded in a contract action absent an independent tort.<sup>97</sup> The court, citing *Spencer*, concluded that no independent tort existed in this case because the tort of bad faith does not exist in Kansas.<sup>98</sup> If the question of whether a bad faith tort exists in a third-party situation was left open in *Spencer*, that question was answered in *Guarantee II*.

Although *Guarantee II* clarified the reach of the *Spencer* holding, that clarification created an inconsistency with a critical statement made by the court in *Guarantee I*. The court held in *Guarantee II* that "a claim that an insurer acted negligently in performing its contractual duty to defend on behalf of the insured does not create a tort action or alter the measure of damages which may be recovered,"<sup>99</sup> but this holding contradicted the description of *Guarantee*'s action in *Guarantee I* as one in tort. Therefore, the court in *Guarantee II* repudiated its description in *Guarantee I*, calling it a "lamentable . . . misstatement" made "inadvertently, but erroneously." The court also attempted to clarify what it called "an area of possible confusion of terminology."<sup>100</sup> The court referred to the terms "good faith," "fair dealing," "without negligence," and "due care" as phrases describing

acceptable conduct of an insurer in performing under an insurance contract. . . . All of these terms are simply statements of the contractual obligation an insurer undertakes under a duty to defend. They do not create a new cause of action or authorize a different measure of damages. They merely seek to broaden the conduct which constitutes breach of contract.<sup>101</sup>

Thus, the court in *Guarantee II* rejected the idea that any insurance contract duties—whether the duty to defend, the duty to settle, or otherwise—are duties "imposed by law." Rather, all such duties are duties "arising under or imposed by agreement," for the breach of which an action lies in contract.<sup>102</sup>

<sup>96</sup> *Guarantee Abstract & Title Co. v. Interstate Fire & Cas. Co.* [*Guarantee II*], 232 Kan. 76, 652 P.2d 665 (1982).

<sup>97</sup> 232 Kan. at 78-79, 652 P.2d at 667.

<sup>98</sup> 232 Kan. at 79, 652 P.2d at 668.

<sup>99</sup> 232 Kan. at 81, 652 P.2d at 669.

<sup>100</sup> 232 Kan. at 80, 652 P.2d at 668.

<sup>101</sup> *Id.*

<sup>102</sup> 232 Kan. at 79, 652 P.2d at 667.

*b. A Summary of the Principles*

To recapitulate, after *Guarantee II* it is the law in Kansas that the insurer owes the insured the general duty to defend. The duty to settle and the duty to appeal are merely two specific aspects of the more general duty to defend. The duty to defend is imposed by the agreement; hence, an action for the breach of the duty lies in contract, not in tort.

What is the standard of care that an insurer must follow in performing this duty? In *Guarantee II*, the court quoted approvingly from its earlier opinion in *Bollinger v. Nuss*, which held that the insurer's obligation was measured both by good faith and by due care (that is, an absence of negligence). In *Guarantee II*, the court explained that it perceived no substantive difference between these two or any similarly worded tests.

What damages may be awarded for breach of this duty? Since the action lies in contract, contract, not tort, damages are recoverable. In contract, the victim of a breach may be compensated for the loss in value of the other party's performance, plus certain consequential damages.<sup>103</sup> Kansas adheres to the *Hadley v. Baxendale*<sup>104</sup> rule that consequential damages are not recoverable unless they naturally follow in the ordinary course of events or the parties reasonably contemplated them.<sup>105</sup> In contract, unlike tort, the injured party may not recover damages for mental anguish or emotional distress. Moreover, the injured party is not entitled to punitive damages absent the existence of an independent tort.<sup>106</sup> In short, by treating the duty to defend as a contract duty, the supreme court limited the remedies available to an insured who has not received the full measure of the insurer's promised performance.

*c. The Problem With Guarantee II*

Although the court in *Guarantee II* clearly held that the insurer's duty to defend, including its component duties, is a contract duty, the court did not embrace fully its own principle. If *Guarantee II* is to be read literally, the court mandated the use of a tort standard of care to determine when a breach of contract has occurred. Contract law is strict, or no-fault, liability: promises are either performed or not performed. Motive, good faith, intent, negligence, and the like are irrelevant to the simple determination of whether a promise has been performed. The court, however, used the good faith and due care standards articulated in *Bollinger v. Nuss* to describe the circumstances under which "contract obligations" in insurance transactions have been fulfilled. The court essentially ruled that an insurer's performance of a contractual duty is not a breach unless the non-performance is in "bad faith" or is "negligent." This is a tort law standard, not a contract law standard.

Given the widespread confusion concerning the meaning of the covenant of good faith in a contract, the court's inconsistency is understandable. It is often said that the duty of good faith and fair dealing is an implied term in every

<sup>103</sup> *Guarantee Abstract & Title Co. v. Interstate Fire & Cas. Co.*, [*Guarantee II*], 232 Kan. 76, 78, 652 P.2d 665, 667 (1982) ("Damages for breach of contract are limited to pecuniary losses sustained. . . .").

<sup>104</sup> 9 Exch. 341, 156 Eng. Rep. 145 (1854).

<sup>105</sup> *E.g.*, *Kansas State Bank v. Overseas Motorsport, Inc.*, 222 Kan. 26, 27, 563 P.2d 414, 415 (1977).

<sup>106</sup> 232 Kan. at 78, 652 P.2d at 667.



contract<sup>107</sup> and that the duty is implied by law.<sup>108</sup> The duty of good faith cannot be disclaimed or altered by the parties; thus, the duty is more than an ordinary "gap-filler," such as the "reasonable price" term which courts supply where no price is specified by the parties.<sup>109</sup> Given this special character of the duty and that it appears to be implied by law, some courts have concluded that the breach of the duty is a tort.<sup>110</sup> Indeed, *Guarantee II* proclaimed that "a tort is a violation of a duty imposed by law."<sup>111</sup> Thus, it was not illogical for the court in *Guarantee I* to refer to Guarantee's action as "one in tort," and it is understandable that "negligence," "due care," and other tort expressions have been used to describe the substance of this contract duty.

But the court in *Guarantee II* was absolutely correct in stating that the duty to defend is a contract duty, not a tort duty. The promise to provide a defense for any covered claim asserted against the insured is an express undertaking by the insurer. Unfortunately, the supreme court endorsed the good faith and without negligence standard as the test for measuring the insurer's compliance with the duty to defend. This is unwise, since the insurer's duty in the standard liability policy to provide a defense is absolute: if a covered claim is asserted against the insured, the insurer must defend it. An insurer's incorrect decision not to defend, even if an honest mistake made in good faith, should be deemed a breach of the contract which entitles the insured to damages.

Two aspects of the duty to defend are not expressly stated in the contract. It is proper to view these "sub-duties"—the duty to settle and the duty to appeal—as omitted terms: if the parties had thought to say anything in the contract about these matters, they would have said, first, that the insurer promises to use good faith and to practice fair dealing in responding to settlement offers and initiating settlement negotiations on the insured's behalf; and second, that the insurer agrees to use good faith and practice fair dealing in deciding whether to appeal adverse judgments against its insured. Thus, the two "sub-duties" are not absolute promises like the duty to provide a defense for a covered claim: the insurer does not promise either to accept every settlement offer or to make settlement offers in every case; nor does the insurer promise to appeal every adverse judgment. The insurer simply promises to use good faith in making these decisions on the insured's behalf, that is, to consider the insured's interests as if those interests were the insurer's own. Failure to do so is a breach of the sub-duty to settle or appeal and simultaneously a breach of the duty to defend; the breach is a breach of *contract*, not a tort. This proposed analysis, unlike the court's approach in *Guarantee II*, treats the duty to provide a defense as the absolute duty which it is. Like the court's approach in *Guarantee II*, this analysis does not expose the insurer to tort damages for a breach of a duty it owes the insured.

<sup>107</sup> RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981).

<sup>108</sup> CORBIN ON CONTRACTS § 654A, at 657-8 (Kaufman Supp., 1982).

<sup>109</sup> See RESTATEMENT (SECOND) OF CONTRACTS, § 33 comment c (1981) (principles similar to those in U.C.C. § 2-305 setting "reasonable price" where price is left open in contract for sale of goods apply to service contracts). The parties can "alter" the implied reasonable price term by designating a particular price; the parties could not agree to not be bound by the duty of good faith.

<sup>110</sup> E.g., *Jarchow v. Transamerica Title Ins. Co.*, 48 Cal. App. 3d 917, 122 Cal. Rptr. 470 (1975); *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 510 P.2d 1032 (1973); *Grand Sheet Metal Prods. Co. v. Protection Mut. Ins. Co.*, 34 Conn. Supp. 46, 375 A.2d 428 (Conn. Super. Ct. 1977); *Ledingham v. Blue Cross*, 29 Ill. App. 3d 339, 330 N.E.2d 540 (1975).

<sup>111</sup> 232 Kan. at 79, 652 P.2d at 667.

The court in *Guarantee II* did not completely understand the proper relationship between the good faith and without negligence standard and the duty to defend. The court's attempted "clarification" of its prior opinions betrays the misunderstanding. Curiously, the court said in *Guarantee II* that "all of these terms," referring to "good faith," "due care," "fair dealing," and the like, "merely seek to broaden the conduct which constitutes breach of contract."<sup>112</sup> Actually the contrary is true: if "good faith" failure to provide a defense is not a breach of the contract duty, then "good faith" and its kindred terms limit, rather than broaden, liability. Under contract principles, the insurer should be held liable any time it fails to defend a claim that ultimately proves to be within the coverage. If the insurer in the express or implied terms of the contract promises to use good faith in responding to settlement offers, the insurer does not breach the contract simply because it spurns a settlement offer and subsequently a judgment is entered in excess of policy limits. However, if the insurer does not act in good faith in rejecting the offer, the promise is breached, and the insurer is absolutely liable.

*d. Further Examination of the Problem in Guarantee II: Winchell as an Example*

The confusion in the supreme court's analysis can be examined further by considering the court of appeals' opinion in *George R. Winchell, Inc. v. Norris*,<sup>113</sup> a case decided prior to *Guarantee II*. In *Winchell*, the plaintiff claimed that an insurer had breached its duty to defend a third-party claim.

Defendant Norris failed to obey a stop sign at an intersection, causing an oncoming truck to swerve and overturn. The truck and its load, both owned by plaintiff, suffered substantial damages. Suit was filed against Norris. Norris did not defend the action, and no counsel appeared on his behalf. Plaintiff secured a default judgment in the amount of approximately \$19,700 and an order of garnishment on Meridian Mutual Insurance Company (Meridian). Meridian moved to dismiss the order on the ground that at the time of the accident, Norris was not a resident of the household of the named insured (Max Norris) and was therefore uninsured by Meridian.

The trial court found both that Norris was a resident of the named insured's household at the time of the accident and that the insurance policy did cover the accident. Judgment was entered against Meridian in the amount of \$10,000, the limits of the policy. As for Norris' liability in excess of the policy limits, the trial court ruled that the insurer had acted in good faith when refusing to provide its insured a defense since a substantial question of coverage existed; the insurer was therefore not liable for the amount in excess of the policy limits.

Plaintiff appealed, but the court of appeals affirmed. Plaintiff argued that when an insurer "wrongfully refuses" to defend its insured, the insured is liable for any judgment rendered against its insured as a result of the refusal, regardless of whether the refusal was made in good faith or whether a settlement offer was made or refused. The court of appeals actually agreed with part of this argument. It took note of the rule in *Bollinger v. Nuss* that requires the insurer to act in

<sup>112</sup> 232 Kan. at 80, 652 P.2d at 669.

<sup>113</sup> 6 Kan. App. 2d 725, 633 P.2d 1174 (1981).

good faith and without negligence in defending and settling claims. The court reasoned, however, that this rule applies "only when the insurer has already decided to defend its insured," and thus is not pertinent where the insurer has refused to defend.<sup>114</sup> In such cases, the court concluded, "the existence of good or bad faith is irrelevant" so long as "no settlement offer is made."<sup>115</sup> A "wrongful refusal"—presumably meaning an erroneous refusal—"is enough to constitute breach."<sup>116</sup> The damages for the breach, under the court's analysis, consist of attorneys' fees and costs, plus the amount of any judgment against the insured up to the limits of the policy. Any judgment in excess of the policy limits is not recoverable, since that damage does not result from the breach: even if the insurer provided the defense, presumably the same judgment would be rendered, and the insured would be liable for the amount of the judgment in excess of the policy limits anyway.<sup>117</sup>

In rejecting the good faith and without negligence tests in circumstances where there is no settlement offer and the insurer erroneously declines to defend the insured, the court of appeals rejected the tort standard of care for determining whether the duty to defend has been breached and adopted the no-fault, contract standard. There was no logical reason why the court of appeals could not have applied the *Bollinger* good faith and without negligence test to the situation where the insurer declined to defend the insured. The duty to defend exists before the lawsuit is filed; the good faith and without negligence test could be applied to a decision not to defend the insured, just as it is to a decision, action, or inaction occurring after the defense commences. Indeed, applying the *Bollinger* test is what *Guarantee II* now seems to require. However, by choosing not to apply the *Bollinger* test and instead opting for a no-fault standard, the court of appeals was consistent: a contract standard of liability was used and contract remedies were awarded.

Consistency of principle and theory is not always good policy, however. In this instance, the contract principles which the court approved do not distinguish between an insurer whose refusal to defend is an honest mistake and an insurer whose refusal is a deliberate effort to subordinate the insured's interests to his own. Under no-fault contract principles, those two insurers would be liable to an insured for the same amount of damages, even though the conduct of the insurer acting in bad faith is much more egregious. This is arguably a major deficiency in a framework which, in the interest of consistency, uses a contract standard of liability and assesses contract damages.

Ironically, while the result in *Winchell* is consistent with *Guarantee II*, the logic of *Winchell*, which treats the insurer's duty to defend as purely a contract duty, probably does not survive *Guarantee II*. In *Guarantee II*, the court reiterated the *Bollinger* good faith and without negligence test as the general standard for the "conduct of an insurer in performing under an insurance contract."<sup>118</sup> It was precisely this test that the court in *Winchell* declined to use to judge the conduct of an insurer in performing its duties.

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<sup>114</sup> *Id.* at 727, 633 P.2d at 1176.

<sup>115</sup> *Id.* at 730, 633 P.2d at 1178.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.* at 729, 633 P.2d at 1177-78.

<sup>118</sup> 232 Kan. at 80, 652 P.2d at 668-69.

Nevertheless, the result in *Winchell* is correct. If there is any deficiency in *Winchell*, it is that the logic of the case leaves no room for subjecting bad faith conduct of insurers to broader remedies that deter conduct thought offensive to public policy. *Guarantee II*, far from ameliorating this deficiency, restricted the insurers' possible exposure for damages by embracing the principle that the insurers' duties are contractually based and then approving a tort standard of care for determining when the contract duty has been breached. The effect of these two conclusions in *Guarantee II* is to limit the instances in which an insurer may be found to have breached the contract and, in those instances, to limit the damages the insurer might have to pay. Usually, because of the element of fault, a tort is harder to establish than a breach of contract, but the reward for carrying the stricter burden is the availability of a more expansive remedy.<sup>119</sup> In Kansas, the supreme court affords the insurer the benefit of both worlds: a standard of care making it more difficult for the plaintiff to establish a breach, and, in the end, the remedies remain restricted.

#### *e. Appraisal and a Suggestion*

The degree of deference to the interests of insurers found in the principles emerging from the *Guarantee* litigation is not needed and may be undesirable. A review of the public policies recognized in Kansas decisions supports this point.

In decisions before and during the survey period, the supreme court adhered to the idea that the duty to settle and the duty to appeal are part of the broader duty to defend.<sup>120</sup> Since the duty to defend is plainly a contractual duty, the court reasoned in *Guarantee II* that the damages assessed an insurer for breach of its duty to defend cannot exceed pecuniary loss suffered by the injured party, absent an independent tort.<sup>121</sup> However, other Kansas decisions have recognized that an insurer's duties can be broader than the contract prescribes. For example, the supreme court has stated on a number of occasions that the relationship between insurer and insured in the third-party situation is also a fiduciary one.<sup>122</sup> Kansas decisions recognize that tort remedies, including punitive damages, are available to the person wronged by a breach of fiduciary duty.<sup>123</sup> Commentary in the Restatement (Second) of Torts states that one who breaches his fiduciary duty "is guilty of tortious conduct to the person for whom he should act [and the] beneficiary is entitled to tort damages for harm caused by the breach of a duty arising from the relation. . . ."<sup>124</sup> Award of punitive damages have been upheld in Kansas cases where the fiduciary relationship is created by contract,<sup>125</sup> as it is

<sup>119</sup> One example is the law of misrepresentation. Relief for misrepresentation in tort is not as available as it is in contract, but the consequences of misrepresentation in tort are more severe than in contract. E. FARNSWORTH, CONTRACTS § 4.10, at 236 (1982).

<sup>120</sup> Although this was recognized in *Guarantee II*, as previously discussed, the idea has earlier roots. In *Bollinger v. Nuss*, 202 Kan. 326, 336, 449 P.2d 502, 510 (1969), the court stated that "the provisions of the policy requiring the insurer to defend also encompass the negotiation of any settlement prior to trial."

<sup>121</sup> 232 Kan. at 78, 652 P.2d at 667.

<sup>122</sup> *Spencer v. Aetna Life & Casualty Ins. Co.*, 227 Kan. 914, 922, 611 P.2d 149, 155 (1980).

<sup>123</sup> *Newton v. Hornblower, Inc.*, 224 Kan. 506, 524, 582 P.2d 1136, 1149 (1978); *Ford v. Guarantee Abstract & Title Co.*, 220 Kan. 244, 261, 553 P.2d 254, 268 (1976).

<sup>124</sup> RESTATEMENT (SECOND) OF TORTS, § 874 comment b (1979).

<sup>125</sup> *Beverly v. McCullick*, 211 Kan. 87, 99, 505 P.2d 624, 634 (1973) (punitive damages available for breach of fiduciary duty arising out of partnership contract); *George v. Bolen-Williams, Realtors*, 2 Kan. App. 2d 385, 393, 580 P.2d 1357, 1364 (1978) (breach of fiduciary duty arising out of contract creating agency relationship between broker and customer justifies award of punitive damages).

in insurance. Protecting the insured's interests under the contract of insurance is an important public policy objective,<sup>126</sup> which is precisely what awards of punitive damages are intended to vindicate. *Guarantee II* failed to comprehend the significance of the fiduciary aspects of the insurer's duties in the third-party situation.<sup>127</sup>

It is understandable that the supreme court should protect insurers from liability for some extracontractual damages. However, immunizing the insurer from liability for all extracontractual damages, as *Guarantee II* does in all situations where there is no independent tort (and, significantly, bad faith is not an independent tort), invites insurers to infringe upon the public policies that broader damage awards sometimes protect. For example, under current Kansas law, an insurer cannot be assessed punitive damages for a wrongful refusal to provide a defense to the insured, even if the refusal is in bad faith.<sup>128</sup> As a result, one might expect some insurers to be more resistant to providing a defense. After all, the most an insurer can be assessed under the contract measure of damages is attorneys' fees (which the insurer would pay anyway to the counsel it retained to defend the suit) plus the policy limits. For some insurers, the risk of incurring these expenses may not be sufficiently strong to discourage aggressive resistance to a demand from an insured for a defense. To the insured whose request for a defense is refused, something for which the insured bargained and paid has been denied. If the insured is unable either to afford an attorney or to purchase an adequate defense, he could incur a judgment in excess of the policy limits for which the insurer, under Kansas law, will not be liable. The same result occurs if an insurer represents to an insured that it will provide the defense, but then fails to do so without giving the insured enough time to secure his own attorney and to prepare an adequate defense. Such conduct should justify a punitive award against the insurer; yet, in Kansas, the insurer will not be liable either for punitive damages or for any judgment in excess of the policy limits.<sup>129</sup> Thus, current Kansas law gives incentives to insurers to subordinate the interests of their insureds to their own. This is contrary to public policy. Malicious refusals to provide defenses should be deterred. Perhaps honest negligence in failing to accept a settlement offer should not be punished, but deliberate or reckless disregard of an

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<sup>126</sup> *Bollinger v. Nuss*, 202 Kan. 326, 333, 449 P.2d 502, 508 (1969).

<sup>127</sup> See *Nordstrom v. Miller*, 227 Kan. 59, 70, 605 P.2d 545, 555 (1980); *Koch v. Merchants Mutual Bonding Co.*, 211 Kan. 397, 402, 507 P.2d 189, 194 (1973).

<sup>128</sup> An outrageous refusal to provide a defense could conceivably constitute the tort of outrage. See *Dawson v. Associates Financial Services Co.*, 215 Kan. 814, 820, 529 P.2d 104, 109 (1974). However, one of the elements of the tort is that the plaintiff suffer "extreme and severe" mental distress. *Hoard v. Shawnee Mission Medical Center*, 233 Kan. 267, 280, 662 P.2d 1214, 1223 (1983); *Roberts v. Saylor*, 230 Kan. 289, 292, 637 P.2d 1175, 1179 (1981). Moreover, the challenged "conduct must be so outrageous in character, and so extreme in degree, as to go beyond the bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society." *Hoard*, 233 Kan. at 283, 662 P.2d at 1225. This is a difficult test to satisfy: only two cases coming before the supreme court and the court of appeals have upheld judgments for plaintiffs claiming "outrage." *Id.* Thus, it is probable that insureds injured by the insurer's breach of the duty to defend will rarely be able to prevail upon a claim of "outrage." See Note, *Torts-Insurance-First Party Bad Faith—Is There an Adequate Remedy in Kansas After Spencer v. Aetna Life & Casualty Insurance Co.*?, 29 KAN. L. REV. 277, 282-84 (1981).

<sup>129</sup> Breaching the duty to provide a defense must be distinguished from breaching the duty to settle. For breach of the duty to settle, the loss in excess of policy limits is a foreseeable and natural consequence of the breach which should be charged to the insurer. The same is not true when the breach is a failure to provide a defense.

insured's interests in settlement should make the insurer vulnerable to more than mere contract damages. What are the possible solutions?

One solution to this situation is to treat the insurer's duties as duties sounding in tort,<sup>130</sup> thus making the insurer vulnerable to the full range of compensatory and punitive damages available in tort. As a matter of policy, this may not be a good idea. The integrity of insurance contracts is an important public policy; making insurers liable for emotional distress and mental anguish damages could result in large judgments that compromise this important policy. At a minimum, the increase in litigation seeking such damages could raise greatly the legal expenses of insurers, which ultimately works to the detriment of policyholders.

A less drastic solution is to loosen the restrictions on awarding punitive damages for insurers' breaches of insurance contracts. At least one state has done this by statute;<sup>131</sup> others states have done so by court-made rule.<sup>132</sup> Given the important public policy aspects of insurance contracts, there is logic in permitting punitive damages to be awarded for breaches of insurance contracts when the insurer's conduct is "tortious in nature," while preserving the more restrictive requirement of an independent tort for other contracts. A limited exception permitting punitive damages in the insurance setting would probably provide an ample deterrent to wrongful conduct by insurers without exposing insurers to unreasonable damage awards.<sup>133</sup>

Another solution, which is similar to loosening the restrictions on awarding punitive damages, is to ease the "foreseeability limitation" on damages for breach of an insurance contract. As noted earlier, Kansas follows the *Hadley v. Baxendale* rule that consequential damages are not recoverable in a contract action unless they naturally follow in the ordinary course of events or the parties reasonably contemplated them. Under this rule, the recovery of an insured where the insurer has breached its duty to defend is limited to the amount payable under the contract, which is typically the policy limits plus the costs of the defense. Damages for emotional distress and mental anguish are not recoverable, presumably because they are not reasonably foreseeable consequences of a breach of contract. The one instance where the insured is permitted to recover more than the policy limits is where the insurer has breached its duty to settle.

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<sup>130</sup> There are two theories that could be used to reach such a result. The first, noted earlier in the text, is based on the current recognition that the relationship between the insurer and insured in the third-party situation is a fiduciary one. Breaches of the insurer's fiduciary duties, which include all aspects of the duty to defend, are torts. See *supra* text accompanying notes 122-127. A second approach reasons as follows: (1) every contract has an implied duty of good faith and fair dealing; (2) this duty is implied by law, see CORBIN ON CONTRACTS § 654A, at 658 (Supp. 1982), (3) since the duty is imposed by law and not the agreement, the breach of the duty is a tort, *Guarantee II*, 232 Kan. at 79, 652 P.2d at 667 ("a tort is a violation of a duty imposed by law"). Presumably, this second approach is incompatible with *Spencer*, 227 Kan. 914, 611 P.2d 149, although the *Spencer* opinion does not specifically explain what is wrong with this approach. One explanation, although not free of all difficulty itself, is that the good faith obligation is actually an *omitted term* of the contract, which is filled by the court. Therefore, bad faith in a contractual transaction is a breach of contract, not a tort.

<sup>131</sup> ARK. STAT. ANN. § 66-3238 (1947) (where payment overdue, insurer shall pay loss plus twelve percent plus attorneys' fees and costs).

<sup>132</sup> See *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 510 P.2d 1032, 108 Cal. Rptr. 480 (1972); *Vernon Fire & Casualty Ins. Co. v. Sharp*, 264 Ind. 599, 349 N.E.2d 173 (1976).

<sup>133</sup> Obviously, if such a test were adopted, it would be important for trial courts to discourage frivolous claims for punitive damages by not hesitating to grant summary judgment for insurers on such claims in appropriate circumstances and by, if necessary, assessing attorneys' fees against plaintiffs making frivolous claims.

Presumably, damages in excess of policy limits are foreseeable if the insurer breaches its duty to settle. Arguably, part of what the insured bargains for in securing an insurance policy is peace of mind in the knowledge that the insurer will defend the insured's interests if a lawsuit is filed against him.<sup>134</sup> By this logic, emotional distress and mental anguish are reasonably contemplated by the parties and follow in the ordinary course of events from an insurer's breach of its duty to defend. This approach to measuring the damages recoverable for breach of the insurer's duty to defend would broaden the possible liability of insurers, thereby providing a deterrent to wrongful conduct<sup>135</sup> without treating the insurer's duties as tort duties.

Another, more workable, alternative is for the legislature to authorize the recovery of attorneys' fees any time the insurer refuses "without just cause or excuse" to perform *any* of its duties under the insurance contract. Presently, section 256 of chapter 40 of the Kansas Statutes permits a court to allow "the plaintiff a reasonable sum as an attorneys' fees for services" in an action against an insurer "on any policy or certificate of any type or kind of insurance, if it appears from the evidence that [the insurer] has refused without just cause or excuse to pay the full amount of such loss."<sup>136</sup> As it stands, the statute permits a trial court to award attorneys' fees if the company "has refused *without just cause or excuse to pay the claim*."<sup>137</sup>

The supreme court has applied section 256 of chapter 40 only in situations where the insured has sued the insurer directly to enforce the insurer's duty to pay proceeds under the insurance contract.<sup>138</sup> Whether the statute applies in other situations is less clear. The Tenth Circuit has held that a garnishor (that is, a third party who has recovered a judgment against the insured) can recover attorneys' fees under section 256,<sup>139</sup> but the supreme court has never so held. The supreme court on one occasion hinted that attorneys' fees are available when an insurer breaches its duty to settle,<sup>140</sup> but this seems inconsistent with the language of the statute. If the insurer wrongfully fails to settle a claim against the insured within policy limits, the problem is not that the insurer fails to pay the claim, but that the insurer has exposed the insured to liability in excess of policy limits. In *Spruill Motors, Inc. v. Universal Underwriters Insurance Co.*,<sup>141</sup> the supreme court considered, but decided against awarding attorneys' fees incurred in an insured's suit against the insurer for breach of the duty to defend.<sup>142</sup> The court might have assumed in *Spruill* that attorneys' fees can be awarded under section

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<sup>134</sup> See *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 58 Cal. Rptr. 13, 19 (1967); but see *Farris v. United States Fidelity and Guaranty Co.*, 284 Ore. 453, 587 P.2d 1015, 1021-22 (1978).

<sup>135</sup> As is the case with any approach which broadens the range of damages that might be awarded, see *supra* note 133, it is important that trial courts discourage frivolous assertions of emotional distress and mental anguish. This may be easier said than done. However, failure to impose any limitations on meritless claims for nonpecuniary loss will expose insurers to the same excessive damage awards that would occur if insurers' duties were treated as tort duties. See *supra* note 130.

<sup>136</sup> KAN. STAT. ANN. § 40-256 (1981).

<sup>137</sup> *Harper v. Prudential Ins. Co. of America*, 233 Kan. 358, 372, 662 P.2d 1264 (1983) (emphasis in original) (quoting KAN. STAT. ANN. § 40-256).

<sup>138</sup> See *Covill v. Phillips*, 455 F. Supp. 485, 487 (D. Kan. 1978).

<sup>139</sup> See *Coleman v. Holecsek*, 542 F.2d 532, 538 (10th Cir. 1976).

<sup>140</sup> *Guarantee Abstract & Title Co. v. Interstate Fire & Cas. Co. (Guarantee I)*, 228 Kan. 532, 539-40, 618 P.2d 1195, 1201 (1980).

<sup>141</sup> 212 Kan. 681, 512 P.2d 403 (1973).

<sup>142</sup> *Id.* at 688-89, 512 P.2d at 409.

256 for breach of the duty to defend because the insured incurs a "loss" when he pays the expenses of defending the third party's suit. However, the language of section 256 seems directed to failures of insurers to pay claims for proceeds due under the policies, not to "losses" in the sense that the insured incurs additional expenses when the insurer does not provide a defense.

A broad reading of section 256 of chapter 40 may well be good policy, but it is doubtful that the legislature ever contemplated the statute being read so expansively. In any event, broadening the scope of section 256—whether by amendment or by judicial construction—would accomplish the same purpose as loosening the restrictions on the recovery of punitive damages for breach of an insurance contract. In addition, this approach would be more workable. Rules that broaden the range of damages recoverable for breach of an insurance contract may be difficult to restrain;<sup>143</sup> if so, the full range of tort damages could be awarded in contract actions. This would be as disadvantageous as treating insurer's duties as tort duties.

### *B. The Duty of Cooperation*

Just as the insurer owes certain duties to the insured, likewise, the insured owes duties to the insurer. In almost all modern liability policies, the insured agrees to cooperate with the insurer in making settlements, in defending suits, and in enforcing subrogation rights. Often, the insured promises to attend hearings, trials, and depositions.<sup>144</sup> The purpose of the "cooperation clause" is to protect the insurer's interest and to prevent collusion between the insured and the injured third party.<sup>145</sup>

The consequences of an insured's breach of his promise to cooperate are derived from general principles of contract law. One such principle is that a party to a contract may not suspend his own performance in response to an insignificant or "immaterial" breach by the other party of one of his duties.<sup>146</sup> This rule prevents undue forfeiture to the party committing an insignificant breach, which could occur if the nonbreaching party responded to the breach by suspending his entire performance. In practice, a nonbreaching party is not entitled to suspend his own performance upon the other party's breach absent some substantial impairment of the non-breaching party's reasonable expectations under the contract.

Derivations of this basic rule are applied in insurance contract cases where the insurer alleges that its duties are discharged due to the insured's breach of its duty of cooperation. It is sometimes said that the insured's breach of the cooperation clause will not relieve the insurer of its responsibilities under the policy unless the lack of cooperation is substantial or material,<sup>147</sup> or unless the insurer can show that it was "prejudiced" by the insured's breach.<sup>148</sup>

<sup>143</sup> See *supra* notes 130, 135.

<sup>144</sup> See Insurance Information Institute, General Liability-Automobile Policy Form, *reprinted in* R. KEETON, *supra* note 29, at 653, 655.

<sup>145</sup> *Watson v. Jones*, 227 Kan. 862, 866-67, 610 P.2d 619, 624 (1980); 8 APPLEMAN, *supra* note 41, § 4771, at 213.

<sup>146</sup> See RESTATEMENT (SECOND) OF CONTRACTS §§ 237, 241, 243 (1981).

<sup>147</sup> 8 APPLEMAN, *supra* note 41, § 4772, at 215-19.

<sup>148</sup> *Id.* § 4773, at 223-24.



The court of appeals considered the nature of the duty of cooperation in *Boone v. Lowry*.<sup>149</sup> When Boone suffered fire damage to his property, he commenced a lawsuit against MFA Insurance Company and its agent, Robert Lowry. Shortly after a summons was served upon him, Lowry left Kansas "for parts unknown." Indeed, Lowry was a dishonest agent engaged in binding applications for insurance and keeping the premiums but failing to forward the applications to MFA. Boone secured a default judgment against Lowry.<sup>150</sup>

To satisfy this judgment, Boone sought to garnish the proceeds of an errors and omissions policy MFA had issued to Lowry. MFA argued, and the trial court agreed, that MFA was not liable under the errors and omissions policy because of the lack of cooperation of its insured, Lowry. The trial court reasoned that Lowry breached the cooperation clause by disappearing after suit was filed, and that this breach prejudiced MFA.

The court of appeals declined to decide whether Lowry's disappearance constituted a breach of the cooperation clause.<sup>151</sup> Although the insured's mere absence from a trial or hearing is not always a breach of the cooperation clause,<sup>152</sup> it hardly seems disputable that the voluntary disappearance of an insured and his subsequent failure to appear for trial against the wishes of the insurer is a breach of the cooperation clause.<sup>153</sup> On the facts of the case, however, the court of appeals held that MFA failed to carry its burden of showing that it would suffer "substantial prejudice" from Lowry's assumed lack of cooperation.<sup>154</sup> The court reasoned that Lowry's presence at trial would have added nothing relevant to MFA's defense of Boone's fairly simple claim that MFA was liable on the errors and omissions policy because its agent had "negligently or corruptly failed to procure insurance after he had given assurance he had done so."<sup>155</sup>

The court's reasoning is troublesome. MFA wanted to prove that Boone set fire to the house and therefore suffered no damage because he was not entitled to proceeds under any policy that might have been in force. Lowry's cooperation was pertinent to this defense, since there were indications that Lowry had knowledge of the origin of the fire and may have even participated in setting it.

The reason that the court of appeals was not receptive to MFA's effort to show prejudice was because MFA had failed to raise the issue of arson when it defended itself in a lawsuit filed by Boone on the allegedly effective policy. Under these circumstances, the court of appeals concluded that MFA had failed to show that "if the cooperation clause had not been breached there was a substantial likelihood that the trier of fact, in an action against the insured, would have

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<sup>149</sup> 8 Kan. App. 2d 293, 657 P.2d 64 (1983).

<sup>150</sup> It is unclear from the court's opinion whether Boone claimed that Lowry was liable under a contract of insurance, see 8 Kan. App. 2d at 294, 657 P.2d at 66 ("appellant filed suit against both agent Lowry and MFA . . . on the theory that a contract of insurance arose by reason of Lowry's conduct") or that Lowry was liable for failure to procure insurance, see 8 Kan. App. 2d at 301, 657 P.2d at 71 ("These issues have no bearing on MFA's liability . . . where its agent negligently or corruptly failed to procure insurance . . ."). Apparently, Boone claimed that Lowry had bound MFA to a contract of insurance, Brief for Appellant at 2, *Boone v. Lowry*, 8 Kan. App. 2d 293, 657 P.2d 64 (1983).

<sup>151</sup> 8 Kan. App. 2d at 299, 657 P.2d at 70 ("Assuming, without deciding, that Lowry's nonappearance at trial breached the cooperation clause . . .").

<sup>152</sup> For example, if the insured is not informed of the trial or hearing, his absence does not amount to lack of cooperation. See 8 APPLEMAN, *supra* note 41, § 4784, at 306-15.

<sup>153</sup> See *id.* § 4784, at 300.

<sup>154</sup> 8 Kan. App. 2d at 29, 302, 657 P.2d at 70, 72.

<sup>155</sup> *Id.* at 301, 657 P.2d at 71.

found in the insured's favor."<sup>156</sup> Since MFA did not raise arson as a possible issue in its own defense and since MFA's only support for its claim of prejudice from Lowry's noncooperation was the information he supposedly would provide on the arson issue, it appears that the court of appeals decided the case correctly. However, it does not appear that the court of appeals applied the correct rules in reaching the correct result.

The court of appeals, citing *Jameson v. Farmers Mutual Automobile Insurance Co.*,<sup>157</sup> said that in Kansas a breach of a cooperation clause will not relieve the insurer of liability unless the breach causes substantial prejudice to the insurer's ability to defend itself.<sup>158</sup> It is not clear that *Jameson* actually stands for that rule. At best, the language in *Jameson* upon which the court of appeals relied is dicta; at worst, the language makes no sense:

This brings us to the question of failure of co-operation on the part of the insured, which is hinted by appellee but not strenuously urged. . . . Along with this point we might mention that inability to locate a policyholder before trial [sic?] must show substantial prejudice to the insurer in defending an action (Appleman's Insurance Law and Practice, § 4773, p. 156) but here the insurer made no effort to defend its insured. Any fact question as to bona fides concerns not only the good faith of the insured but that of the insurer as well.<sup>159</sup>

The syntax of the quoted passage suggests that one or more sentences were inadvertently omitted from the published opinion. Whatever the passage might mean, *Jameson* is weak authority for the substantial prejudice test.

Interestingly, the supreme court's most recent decision on the duty of cooperation, *Watson v. Jones*,<sup>160</sup> makes no mention of the substantial prejudice test. Moreover, the principles announced in *Watson* conceivably mandate a different result in *Boone*:

[A]n insurer in asserting a policy defense of noncooperation has the burden of proof to establish noncooperation when garnished by a judgment creditor of its assured. The insurer must prove it acted in good faith and attempted to secure the attendance and testimony of its assured at the trial and that the assured's failure to appear and testify at trial was due to an intentional refusal to cooperate, despite timely and diligent efforts by the insurer.<sup>161</sup>

This test contains no separate requirement of "substantial prejudice," permitting an inference that when the insured deliberately refuses to make himself available for trial, the insured's conduct is *per se* "substantially prejudicial."

Some clarification in this area is necessary. Abandoning the substantial prejudice test and relying instead on the "materiality" doctrine of traditional contract law would be an improvement. As the Appleman treatise explains, the substantial prejudice test is

probably salutary where it is evident that the insured's infraction did not seriously impair the insurer's investigation or defense of the action. But if

<sup>156</sup> *Id.* at 302, 657 P.2d at 72.

<sup>157</sup> 181 Kan. 120, 309 P.2d at 394 (1957).

<sup>158</sup> 8 Kan. App. 2d at 299, 657 P.2d at 70.

<sup>159</sup> 181 Kan. at 127, 309 P.2d at 400.

<sup>160</sup> 227 Kan. 862, 610 P.2d 619 (1980).

<sup>161</sup> *Id.* at 868, 610 P.2d at 625.

the rule is carried to the point of imposing an almost insurmountable burden of proving that the verdict was the result of lack of cooperation, it would amount to a perversion of such contractual provision.<sup>162</sup>

The court of appeals carried the rule too far when it held MFA to the burden of establishing "at the very least that if the cooperation clause had not been breached there was a substantial likelihood that the trier of fact, in an action against the insured would have found in the insured's favor."<sup>163</sup> The court of appeals should have decided the case on narrower grounds: assuming *arguendo* that Lowry breached the noncooperation clause, the breach was immaterial under the specific circumstances of this case and therefore did not relieve MFA of its contract obligations.

### C. The Duty to Pay Proceeds

One of the most important duties of an insurer in a first-party situation is the duty to pay proceeds to the insured when a covered loss occurs. This duty, perhaps more than any other, is what the insured bargains for when he purchases a policy of insurance. During the survey period, Kansas courts explored several aspects of this duty.

#### 1. "Other Insurance" Clauses

Because insurance is so pervasive, overlapping coverage is fairly common.<sup>164</sup> All modern property, most liability, and many health, accident, and medical policies contain "other insurance" clauses.<sup>165</sup> The purpose of an other insurance clause is to reduce or eliminate the liability of the insurer where the insured possesses other coverage of the same risk.<sup>166</sup>

There are three basic types of "other insurance" clauses. "Escape" clauses provide that the insurer shall have no liability if there is other valid and collectable insurance. "Pro rata" clauses declare that the insurer's liability shall be limited to a proportion of the loss not exceeding its proportion of the total insurance coverage. "Excess" clauses provide that the insurer shall reimburse only the loss exceeding the coverage of other valid and collectable insurance.<sup>167</sup>

Since "other insurance" clauses are widely used, it often happens that an insured suffers a loss or incurs a liability covered by two or more policies containing conflicting other insurance clauses. This was the situation in *Western Casualty and Surety Co. v. Universal Underwriters Insurance Co.*,<sup>168</sup> decided by the supreme court. A school employee was involved in an accident while driving a rented van. Both

<sup>162</sup> 8 APPLEMAN, *supra* note 41, § 4773, at 228.

<sup>163</sup> 8 Kan. App. 2d at 302, 657 P.2d at 72.

<sup>164</sup> For an extensive list of examples, see Kurtrock, *Overlapping Liability Coverage—The "Other Insurance" Provision*, 25 FED. OF INS. COUNSEL Q. 45 (1974), quoted in 8A APPLEMAN, *supra* note 41, § 4906, at 342-43.

<sup>165</sup> Other insurance clauses most often appear in policies where the principle of indemnity is important. See note 166 *infra*. Other insurance clauses are ordinarily irrelevant in the life insurance context. See R. KEETON, *supra* note 29, at 169-70.

<sup>166</sup> Other insurance clauses promote the policy of indemnity, since the clauses prevent the insured from recovering more than his actual loss. *Id.*, at 168. In property insurance, the fact that such clauses are widely used should deter anyone inclined to purchase overlapping coverage in the hope of making a profit by intentionally destroying insured property.

<sup>167</sup> See *Western Cas. & Surety Co. v. Universal Underwriters Ins. Co.*, 232 Kan. 606, 610-11, 657 P.2d 576, 579-80 (1983); R. KEETON, *supra* note 29, at 171.

<sup>168</sup> 232 Kan. 606, 657 P.2d 576 (1983).

the school district which employed him and the lessor of the van carried insurance covering the resulting damage and personal injury. The two policies contained conflicting "excess" "other insurance" provisions.

The court first held that the conflicting clauses were "mutually repugnant" and therefore were to be disregarded.<sup>169</sup> This holding is consistent with the growing minority view.<sup>170</sup> The court limited its holding to the situation where two excess coverage clauses are involved, but the court's ruling should be reached anytime there is an irreconcilable conflict between "other insurance" clauses.<sup>171</sup>

When the court in *Western Casually* held the other insurance clauses to be mutually repugnant, the policies functioned, in effect, as providing "dual primary coverage."<sup>172</sup> This left the problem of apportioning the loss between the two policies.

No Kansas court had previously confronted this question. In other states two approaches have emerged to the proration problem. Most courts require the insurers to pay shares of the loss proportional to their limits of coverage.<sup>173</sup> This rule, sometimes called the "Lamb-Weston" rule since it was articulated in an Oregon case of that name,<sup>174</sup> is based on the idea that the insurer should bear a proportion of the loss equal to the proportion of the undertaken risk, and this proportion of risk is best measured by comparing policy limits. For example, suppose the insured suffers a loss of \$40,000, which is covered by both Policy X and Policy Y. Policy X has limits of \$75,000, and Policy Y has limits of \$25,000. The policies have mutually repugnant excess coverage clauses. Under the Lamb-Weston rule, Policy X covers seventy-five percent of the loss, or \$30,000, and Policy Y covers twenty-five percent of the loss, or \$10,000.

The Lamb-Weston method of proration has been rejected in a minority of jurisdictions, but the minority is growing.<sup>175</sup> The minority view argues correctly that the cost of insurance does not increase proportionately with increasing policy limits.<sup>176</sup> Since most losses are small and few are total, providing the lowest "layers" of coverage is more costly to the insurer. This is why the price to the consumer of the lowest "layers" is higher: once minimum coverage is purchased, substantial supplemental coverage can be purchased at a relatively slight increase in cost.<sup>177</sup>

Therefore, unless the policy limits of two or more policies are equal, apportioning a loss according to policy limits does not equally apportion the risk the insurers have assumed. Apportioning the loss according to premiums paid would do so, but because of the difficult premium payment computation over the life of an

<sup>169</sup> *Id.* at 611, 657 P.2d at 580.

<sup>170</sup> *Jones v. Medox, Inc.*, 413 A.2d 1288, (D.C. Ct. App. 1978); *see generally* Annot., 12 A.L.R.4th 993 (1982).

<sup>171</sup> *See* R. KEETON, *supra* note 29, at 172 ("because of the public interests at stake courts should decline to legitimate the development of labyrinthian policy provisions the reconciliation of which requires inordinately complex analysis and occasions wasteful litigation").

<sup>172</sup> 232 Kan. at 611, 657 P.2d at 580.

<sup>173</sup> *Id.* at 612, 657 P.2d at 580 (quoting *Carriers Ins. Co. v. Am. Policyholders' Ins. Co.*, 404 A.2d 216, 221-22 (Me. 1979)); R. KEETON, *supra* note 29, at 171.

<sup>174</sup> *Lamb-Weston, Inc. v. Oregon Auto. Ins. Co.*, 219 Ore. 110, 341 P.2d 110 (1959).

<sup>175</sup> *Carriers Ins. Co.*, *supra* note 173, at 221.

<sup>176</sup> 232 Kan. at 612, 657 P.2d at 580 (quoting *Carriers Ins. Co.*, 404 A.2d at 221-22).

<sup>177</sup> *See* R. KEETON, *supra* note 29, at 137 ("since the insurer will more often be required to pay the first thousand than the last, some losses being small, the cost to the insurer of providing the first thousand of coverage is considerably higher than the cost of providing the fifteenth thousand").

insurance policy and the many variables affecting premium levels, no modern court follows this approach.<sup>178</sup> However, a growing minority of courts have approved the following approach: the insurers with applicable policies pay equal shares of the loss up to the limits of their respective coverages. In *Western Casualty*, the supreme court aligned Kansas with this minority view.<sup>179</sup> This approach would change the result in the above example: Policy X and Policy Y would each pay \$20,000. If the loss in the example were \$60,000 instead of \$40,000, the insurers would share the loss equally until the limits of Policy Y were exhausted, and then Policy X would cover the rest of the loss. When the computation is completed, Policy X pays \$35,000, and Policy Y pays \$25,000.

The minority view is sound, and the supreme court was wise to adopt it. Unfortunately, there are many permutations to the "other insurance" clause problem<sup>180</sup> which were not presented for decision in *Western Casualty*. Perhaps the spirit of the decision will encourage most insurers to settle these disputes. However, in major catastrophes triggering many different insurance coverages, complex, time-consuming litigation is probably unavoidable, as a great deal of law remains to be created on this complicated issue.<sup>181</sup>

## 2. Interpleader

Occasionally an insurer is confronted with conflicting claims to the proceeds of an insurance policy. The insurer must proceed with care, lest it pay the proceeds to one person, subsequently learn when the proceeds cannot be retrieved that someone else should have received payment, and be required to make a second payment. In such a situation, the procedural device of interpleader provides the insurer with protection. In *Mitchelson v. Travelers Ins. Co.*,<sup>182</sup> an insurer chose not to interplead when faced with conflicting claims. The manner in which the supreme court disposed of the ensuing litigation is instructive as to the insurer's duties in the conflicting claim situation.

The insured, whose life was insured under a policy issued by Travelers for \$100,000 in the event of accidental death, died of a gunshot wound on May 3, 1977. His wife, the beneficiary, was charged with murdering her husband. A few weeks after the insured's death, the wife assigned her rights as beneficiary to her attorney, who notified Travelers of the assignment and made a demand for payment.<sup>183</sup>

On November 9, 1977, six months after the insured's death, Travelers proposed to attorneys for the executor of the insured's estate and to the wife's attorney that an escrow agreement be executed, pursuant to which Travelers would pay the proceeds of the policy into escrow pending determination of the proper payee. No agreement was reached. On November 14, 1978, one year after Travelers made its escrow proposal, the executor and the wife (now with new counsel)

<sup>178</sup> 8A APPLEMAN, *supra* note 41, § 4906, at 346 (1981).

<sup>179</sup> 232 Kan. at 613, 657 P.2d at 581.

<sup>180</sup> See generally Alleman, *Resolving the "Other Insurance" Dilemma: Ordering Disputes Among Primary and Excess Policies*, 30 KAN. L. REV. 75 (1981).

<sup>181</sup> *Id.*

<sup>182</sup> 229 Kan. 567, 629 P.2d 143 (1981).

<sup>183</sup> In his letter to Travelers, the attorney noted that the wife was charged with murder of the insured, and that conviction of that offense would disqualify her from receiving the proceeds. 229 Kan. at 568, 629 P.2d at 144.

filed a declaratory judgment action against Travelers to determine the proceeds' ownership. Plaintiffs also sought an order requiring Travelers to pay the policy proceeds plus interest into court. In response Travelers alleged that there were conflicting claims to the proceeds, asked that the wife's former attorney be made a party, and volunteered to pay the sum into court pursuant to court order. However, no such order was entered, and no action was taken in the case until August 1979. On August 6, the wife's former attorney wrote to Travelers advising that he had reassigned the wife's interests in the proceeds to her. On August 22, plaintiffs moved for summary judgment. Travelers' response, filed on October 12, opposed summary judgment on the ground that the record did not contain all necessary facts. The wife's conviction for murder became final on November 5. On November 9, the trial court entered summary judgment for plaintiffs in the amount of \$100,000, plus interest at six percent running from August 6, 1979.<sup>184</sup>

The executor appealed on the ground that the estate was entitled to more prejudgment interest than the trial court allowed. Specifically, the executor contended that the interest should run from either the date of death or the date when proof of loss was furnished. The four-justice majority said that whether prejudgment interest is assessed "is usually resolved by examining the equitable and factual circumstances of each case."<sup>185</sup> The court discussed several such circumstances in the instant case, noting that Travelers attempted to negotiate an escrow agreement at an early stage, and later (after the suit was filed against it), offered to pay the proceeds into escrow pursuant to court order, although the court did acknowledge that Travelers neither sought nor obtained such an order.<sup>186</sup> The three dissenting justices noted that Travelers paid no interest on the proceeds for twenty-seven months (an estimated benefit to Travelers in excess of \$20,000) and argued that nothing prevented Travelers from paying the funds into court on its own initiative.<sup>187</sup>

The majority is correct that there must be flexibility in the rules determining when prejudgment interest on the proceeds of an insurance policy begins. The insurer must be afforded "a reasonable time to determine whether there are adverse claims of substance and to *prosecute any appropriate interpleader action*."<sup>188</sup> However, it is also true, as the excerpt quoted by the court states, "unreasonable delay or failure on the part of the stakeholder in depositing the funds in court may subject it to liability for interest on the funds."<sup>189</sup> These principles approved by the majority would seem to require Travelers to take more initiative than it displayed in this case. Travelers did not dispute that it was liable to someone, and there were only three persons conceivably entitled to the proceeds. Once negotiations for an escrow agreement broke down,<sup>190</sup> Travelers could have

<sup>184</sup> *Id.* at 568-69, 629 P.2d at 144.

<sup>185</sup> 229 Kan. at 571, 629 P.2d at 146.

<sup>186</sup> 229 Kan. at 572, 629 P.2d at 147.

<sup>187</sup> 229 Kan. at 574, 629 P.2d at 148 (Schroeder, C.J., dissenting).

<sup>188</sup> 229 Kan. at 571, 629 P.2d at 146 (quoting *Powers v. Metropolitan Life Ins. Co.*, 439 F.2d 605, 608 (D.C. Cir. 1971)) (emphasis added).

<sup>189</sup> *Id.*

<sup>190</sup> It is not clear from the opinion why Travelers waited six months to attempt to negotiate a voluntary escrow agreement. The executor of the estate "asked Travelers to hold the proceeds, with interest, until the criminal charges against [the wife] were resolved." 229 Kan. at 568, 629 P.2d at 145. This request, standing alone, did not justify Travelers in retaining the proceeds *without* interest.

commenced an interpleader action in which it named all possible claimants as defendants and deposited the stake in court.<sup>191</sup> As one commentator states, "[t]he better rule would seem to be that if the insurer admits its liability on the policy to some person, it should be required to interplead the conflicting claimants promptly."<sup>192</sup>

Even though Travelers was ultimately vindicated in part, the fact that the supreme court split four-to-three demonstrates that Travelers ran a substantial risk by not paying the proceedings into court as soon as it understood the situation. Insurers confronted with similar situations in the future would be well advised to commence interpleader actions once reasonable efforts to arrange voluntary escrow arrangements fail.

### 3. *Disqualification of Beneficiaries*

All jurisdictions hold that a beneficiary convicted of murdering the insured is not entitled to the proceeds of a policy of personal insurance.<sup>193</sup> Beyond that basic principle, courts diverge. In *Harper v. Prudential Ins. Co. of America*,<sup>194</sup> the supreme court clarified a number of aspects of Kansas law concerning disqualification of primary beneficiaries and the duties of the insurer to contingent beneficiaries.

In *Harper*, Prudential issued a policy insuring the life of Jan Fenton, and designating her husband Norman as the primary beneficiary and her two-week-old son, Eric, as contingent beneficiary. Approximately six weeks later, Jan was killed in her home by a gunshot wound to the head; her husband was the primary suspect. Prudential received a claim for proceeds from Norman, together with a newspaper report showing that foul play was involved in the insured's death. Before paying the proceeds to Norman, Prudential sent an investigator to inquire about the circumstances of the death. The investigator learned from numerous law enforcement officials that Norman was the prime suspect, that a number of them believed Norman to be the killer, but that insufficient evidence existed at that time to arrest him. Using information from law enforcement personnel, the investigator reported to Prudential:

I am probably over 99% certain that the beneficiary . . . shot and killed the insured. The physical evidence is quite strong. . . . I believe that there is enough doubt that we could with justification delay payment.<sup>195</sup>

About ten days after receiving this report, Prudential paid the proceeds of the policy to Norman. Two years later Norman was indicted for murdering his wife, and he was convicted the following year. Shortly after the conviction, Eric's

<sup>191</sup> In its brief, Travelers argued this was not possible because no claimant asserted a present right to be paid. Brief of Travelers Ins. Co., at 10. This argument is off the mark, because interpleader is available to join those who claim *or may claim* some interest in the stake in one action. *Club Exchange Corp. v. Searing*, 222 Kan. 659, 567 P.2d 1353 (1977). Travelers also argued that the interpleader action could not have decided who was entitled to the proceeds until the criminal action was completed. Brief, *supra*, at 10. This is correct, but it does not mean Travelers could not have commenced the interpleader action, which would have been stayed pending the outcome of the criminal proceedings, and deposited the stake, *to which Travelers admitted it was not entitled*, in court.

<sup>192</sup> 3 APPLEMAN, *supra* note 41, § 1584, at 325 (1967).

<sup>193</sup> 3B APPLEMAN, *supra* note 41, § 481, at 308 (1981).

<sup>194</sup> 233 Kan. 358, 662 P.2d 1264 (1983).

<sup>195</sup> 233 Kan. at 361-62, 662 P.2d at 1268 (emphasis deleted).

guardians filed an action on his behalf against Prudential to recover the proceeds of the policy. The trial court entered judgment for Eric.

Prudential appealed on a number of grounds, but before dealing with these issues, the supreme court clarified and modified Kansas law dealing with disqualification of beneficiaries. After tracing the development of Kansas law, the court observed that under existing authorities a beneficiary who feloniously killed the insured was not barred from receiving the proceeds of the insurance until convicted of the crime.<sup>196</sup> The court stated that this "ill-conceived" rule "should no longer be followed in this state," and that "we should adopt the common-law rule which is almost universally followed in this country and which bars the beneficiary of a life insurance policy who feloniously kills the insured from recovering under the policy whether convicted or not."<sup>197</sup>

Proceeding to Prudential's first argument concerning the insurer's duty to the contingent beneficiary when the primary beneficiary is suspected of murdering the insured, the court explained that the "good faith" standard governs the insurer's duty. To satisfy this standard, the insurer must make

a reasonable and prudent prepayment investigation when the company is aware of suspicious circumstances involving the beneficiary in the death of the insured. The obligation of good faith is not violated unless a reasonably prudent investigator would have uncovered facts which would have defeated the beneficiary's claim.<sup>198</sup>

Thus, the only time an insurer is immune from liability for paying the proceeds to the contingent beneficiary is when it does so "in good faith and without knowledge of facts which may defeat the primary beneficiary's claim."<sup>199</sup> In the court's view, Prudential failed to meet this standard. Prudential had notice from criminal authorities that the beneficiary's participation in the insured's death was the subject of a current investigation. Under these circumstances, Prudential should have "either delayed making payment to Fenton or filed an interpleader action."<sup>200</sup>

Two justices dissented, but their concerns do not seem substantial. It is true that the decision will cause insurance companies "to withhold payment of the proceeds of the policy" when the insured dies under suspicious circumstances,<sup>201</sup> but this is prudent if there is reasonable belief that the beneficiary is not qualified to receive the proceeds. It is not correct, as the dissent argued, that the proceeds will be "withheld by the insurer until authorities have determined the insured

<sup>196</sup> 233 Kan. at 364-68, 662 P.2d at 1269-72.

<sup>197</sup> 233 Kan. at 367, 662 P.2d at 1271. Prior Kansas law, primarily articulated in *Noller v. Aetna Life Ins. Co.*, 142 Kan. 35, 46 P.2d 22 (1935), was not based on the common-law rule prevailing in most jurisdictions. Instead, the rule disqualifying beneficiaries who killed the insured was based on a statute, now codified at KAN. STAT. ANN. § 59-513 (1976), concerning descent and distribution of a decedent's estate and property. Historically, courts in most states have disqualified the beneficiary on grounds of public policy, and have held that statutes relating to succession in probate do not apply to the claim of an insurance beneficiary. 1B APPLEMAN, *supra* note 41, § 481, at 312. Thus, prior to *Harper*, the Kansas approach on the issue was unique. In one significant respect, the *Noller* decision was ahead of its time: it was predicated on the realization, which courts in other states have been slower to comprehend, that there is no justification for different disqualification rules for life insurance beneficiaries and estate beneficiaries. See R. KEETON, *supra* note 29, at 262-63. Nothing in *Harper* undermines this rather perceptive aspect of *Noller*.

<sup>198</sup> 233 Kan. at 370, 662 P.2d at 1273.

<sup>199</sup> *Id.* (emphasis deleted).

<sup>200</sup> *Id.* at 371, 662 P.2d at 1274.

<sup>201</sup> *Id.* at 373, 662 P.2d at 1275 (Lockett, J., dissenting).



died of natural causes.”<sup>202</sup> Rather, the proceeds will be withheld only until it is reasonably clear that the beneficiary did not intentionally cause the insured’s death. Interpleading will “dissipate the proceeds of the insurance policy,”<sup>203</sup> but only to a slight extent: for an insurer’s counsel, interpleader is a routine pleading that in the ordinary case justifies a modest fee. It is true that the “primary beneficiary [is] required to defend in a civil suit” even though he may have nothing to do with the death of the insured,<sup>204</sup> but this is not particularly burdensome; as a practical matter, the interpleader action remains dormant until information that is dispositive of the issues raised by the interpleader is developed in other proceedings, such as a criminal trial. In short, the court’s decision in *Harper* is sound.

In some circumstances, however, the killing of the insured may do more than disqualify the beneficiary. This was the case in *Chute v. Old American Insurance Co.*<sup>205</sup>

Willis Upshaw was employed by Jan and Bill Carpenter. The Carpenters “enticed” Upshaw to apply for two policies of life insurance and name them as the beneficiaries.<sup>206</sup> The policies were issued by Old American. The Carpenters purchased the policies and paid the premiums.<sup>207</sup> Prior to the issuance and delivery of the policies and the payment of premiums, the beneficiaries devised and implemented a plan to murder Upshaw. The Carpenters were convicted, and thereby disqualified from collecting the proceeds of the two Old American policies.

Following the Carpenters’ disqualification, the administratrix of the Upshaw estate brought a suit against Old American to recover on the two policies. After a trial on the merits, the trial court entered judgment for Old American, on the ground that the Carpenters intent to murder Upshaw at the time they obtained the policies constituted fraud which voided the policies *ab initio*.<sup>208</sup> The administratrix appealed.

The court of appeals first noted the rule that “an insurer is not relieved of liability under its policy simply because the beneficiary killed the insured.”<sup>209</sup> However, the rule is not without exceptions, one of which was pertinent: the insurer is not liable where the policy is procured by a beneficiary who intends at that time to murder the insured.<sup>210</sup> This rule, sometimes called the “predetermination to kill” rule, is based on the general principle of contract law that a contract induced by fraud is “void,” meaning that no contract is even formed.<sup>211</sup>

The administratrix argued that the predetermination to kill rule did not apply in the instant case because no evidence was presented at trial that the Carpenters formed an intent to murder Upshaw prior to or at the time the insurance applications were submitted. By this argument, an intent to murder the insured, formed while the application for insurance was pending, would not constitute

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<sup>202</sup> *Id.*

<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> 6 Kan. App. 2d 412, 629 P.2d 734 (1981).

<sup>206</sup> *Id.* at 421, 629 P.2d at 742.

<sup>207</sup> *Id.* at 413, 629 P.2d at 736-37.

<sup>208</sup> *Id.* at 414, 629 P.2d at 737.

<sup>209</sup> *Id.* at 415, 629 P.2d at 738.

<sup>210</sup> *Id.* at 416, 629 P.2d at 741. See 1B APPLEMAN, *supra* note 41, § 482, at 314.

<sup>211</sup> See E. FARNSWORTH, CONTRACTS 235 (1982).

fraud preventing a valid insurance contract from being formed. The court of appeals properly rejected this argument, holding that fraud in connection with any aspect of the "procurement" of the policy prevents a valid insurance contract from coming into existence.<sup>212</sup> Under this broader view, no contract is formed if the intent to kill is formed prior to or at the time the policy is applied for, issued, or delivered, or prior to or at the time a premium is paid.<sup>213</sup>

Plaintiff also argued that Old American was estopped from presenting its defense of fraud because it failed to comply with section 419 of chapter 40 of the Kansas Statutes.<sup>214</sup> This statute prevents an insurer from relying on the defense of misrepresentation unless "at or before the trial" the insurer "shall deposit in court for the benefit of the plaintiff the premiums received on such policies." The court of appeals reasoned that the "clear purpose of the statute is to prevent insurance companies from retaining the benefits of premiums paid while at the same time denying coverage."<sup>215</sup> In this case, the trial court did not err in rejecting the defense because the "issue was not raised until final arguments and would not at that late date estop defendant from proving the contract void ab initio."<sup>216</sup>

The administratrix's argument, though unsuccessful, did call attention to an ambiguity in section 419 of chapter 40. In this situation, the "plaintiff," the administratrix, was not legally entitled to the return of the premiums because they had been paid by the disqualified beneficiaries, not the insured. In the instant case, Old American tendered the premiums to the Carpenters' attorney. This was a logical thing to do, but as a technical matter that tender did not satisfy the statute. Although the problem will rarely surface, some fine-tuning of section 419 seems warranted.

If the legislature ever attends to section 419 of chapter 40, it would also make sense to amend the statute to provide that the insurer need not deposit in court or otherwise return any premium collected for any period during which it was bound on the risk of death under circumstances that would have given rise to liability.<sup>217</sup> This matter, which did not surface in *Chute*, will not arise often either. But if the statute is one day revised, these two changes should be made.

### III. THE SCOPE OF COVERAGE

Determining what persons or interests are covered by insurance and what risks are transferred are major recurring problems in insurance law. These problems are often the root of several common questions: What does the policy cover? Who is an insured? What risks are excluded? What does the policy mean? What does a particular provision, phrase or word in the policy mean? During

<sup>212</sup> 6 Kan. App. 2d at 420-21, 629 P.2d at 741.

<sup>213</sup> 6 Kan. App. 2d at 421, 629 P.2d at 741 (quoting *Colyer's Administrator v. New York Life Ins. Co.*, 300 Ky. 189, 191, 188 S.W.2d 313, 314 (1945)).

<sup>214</sup> KAN. STAT. ANN. § 40-419 (1981).

<sup>215</sup> 6 Kan. App. 2d at 423, 629 P.2d at 743.

<sup>216</sup> *Id.*

<sup>217</sup> See R. KEETON, *supra* note 29, at 268. For example, suppose after a policy is procured, the insured in a supplemental communication with the insurer (perhaps regarding a change in benefits) makes a material misrepresentation to the insurer that is the basis for a defense on the policy. The insurer should not be required to return premiums for the period during which the insurer did extend valid coverage to the insured.

the survey period, the supreme court and the court of appeals decided several cases involving the scope of coverage.

*A. Coverage Provisions, Exclusions, and Burden of Proof*

An insurance company that seeks to avoid liability on the ground that the loss falls within an *exclusion* has the burden of proof. However, the insured has the burden in the first instance to prove that the loss is within the policy's *coverage*.<sup>218</sup> Therefore, it is important to distinguish between a coverage provision and an exclusionary clause.

This distinction determined the outcome in *Cloud v. Train Trinity Companies*,<sup>219</sup> a court of appeals decision. Plaintiff purchased a policy that insured her property against ten named perils. One of these perils was loss due to windstorm or hail, but excluding interior damage caused by rain, snow, sand, or dust, whether driven by wind or not, unless the building first sustained actual damage to the roof by direct force of wind or hail. The stipulated facts on which the case was submitted to the trial court stated only that plaintiff's residence was damaged "as a result of snow melting and leaking into the house." The trial court nevertheless entered judgment for the insured, and the insurer appealed.

The court of appeals reversed. It observed that nothing in the stipulated facts linked the leak in the roof to a covered peril. This was a critical omission. Plaintiff had the burden to prove a loss within a covered peril. Plaintiff claimed coverage under the peril "windstorm or hail," but the insurer could be liable for damage caused by the leaking roof only if the leak developed after the roof sustained damage by direct force of wind or hail. Nothing in the stipulated facts mentioned "wind or hail." Accordingly, plaintiff failed to carry her burden of showing a loss within a covered peril.<sup>220</sup>

The distinction between a coverage provision and an exclusion clause, which was critical to the outcome in *Cloud*, has had surprisingly little development in the courts.<sup>221</sup> Most homeowner's policies are written as "specified risk" policies: the insurance only covers certain named risks, and it is the burden of the insured to show that a loss is within one of those risks.<sup>222</sup> In contrast, an all-risk policy covers any physical loss to the property unless the insurer demonstrates that the loss falls within a specific exclusion. All-risk insurance is more favorable to the insured because there is less likelihood of a gap in coverage. However, the most important consequences of the distinction between specified risk and all-risk policies concern who bears the burden of proof, a consequence all too obvious to the losing plaintiff in *Cloud*.

*B. The Effect of a Severability of Interests Provision on Exclusionary Clauses*

In *Rose Construction Co. v. Gravatt*,<sup>223</sup> the supreme court considered the effect of a

<sup>218</sup> These rules are summarized, and citations are provided, in *Cloud v. Trinity Companies*, 5 Kan. App. 2d 437, 438, 617 P.2d 1277 (1980). The rules were also applied in *United School District No. 285 v. St. Paul Fire and Marine Ins. Co.*, 6 Kan. App. 2d 244, 245-46, 627 P.2d 1140, 1147 (1981).

<sup>219</sup> 5 Kan. App. 2d 437, 617 P.2d 1277 (1980).

<sup>220</sup> *Id.* at 439, 617 P.2d at 1279.

<sup>221</sup> R. KEETON, *supra* note 29, at 272.

<sup>222</sup> *Id.* at 271.

<sup>223</sup> 231 Kan. 196, 642 P.2d 569 (1982).

severability of interests provision on an exclusionary clause in a liability policy.

Plaintiff Rose Construction Company (Rose) leased a building to Smelser, who operated a business in the building. Gravatt, one of Smelser's employees, damaged the building while operating one of Smelser's vehicles. The vehicle was insured under a policy purchased by Smelser from Farmers Insurance Company, Inc. (Farmers). Rose obtained judgments against Smelser and Gravatt, and sought to garnish Farmers to collect the Gravatt judgment.

Under the policy, Smelser was the "named insured," but Gravatt was also an "insured," because he was "any other person . . . using such automobile . . . with his [i.e. Smelser's] permission." Farmers argued, however, that Gravatt was not covered due to an exclusion in the policy for "damage to . . . (b) property rented to or in charge of the insured . . . or (c) property as to which the insured is for any purpose exercising physical control."

Smelser, the employer-lessee, was clearly in charge and in control of the property. As such, if the garnishment were to satisfy the Smelser judgment, the exclusion would obviously apply. However, Rose sought to satisfy the Gravatt judgment. Gravatt neither rented nor controlled the damaged building. So, the question presented in *Rose Construction* was whether Gravatt was excluded from coverage because he was employed by someone to whom the exclusionary clause did apply. The court's answer was negative. The exclusion applied to "*the* insured," not "*any* insured." Since Gravatt neither rented nor controlled the damaged property, the exclusion did not apply to him.<sup>224</sup> The court described this as "a strong argument,"<sup>225</sup> but the court's holding was that the policy's severability of interests provision, which provided that the insurance "applies separately to each insured," "required a finding that the exclusions are to be applied only against the insured for whom coverage is sought."<sup>226</sup> Accordingly, Rose Construction's loss was covered by the Farmers policy.

### *C. Construction and Interpretation of Specific Words and Phrases*

As with any contract, the obligations of the insurer and insured often depend on the meaning of particular provisions, phrases, or words in the policy. Some scholars have drawn a distinction between "construction" and "interpretation." The distinction is difficult to make in most situations and will not be followed here, but it is nevertheless worthy of mention.<sup>227</sup> Interpretation is used narrowly by these writers to refer to "the process by which a court determines the meaning that the parties themselves attached to their language."<sup>228</sup> Construction refers to "the process by which a court determines the meaning that will be given to the language of the contract in order to determine its legal effect."<sup>229</sup> Thus, the process of interpretation might possibly yield one meaning, while the process of construction might yield another.

Further, whatever the parties themselves might have meant, a court promot-

<sup>224</sup> *Id.* at 197, 642 P.2d at 571.

<sup>225</sup> *Id.* at 198, 642 P.2d at 571.

<sup>226</sup> *Id.* at 197-98, 642 P.2d at 571.

<sup>227</sup> See generally E. FARNSWORTH, *CONTRACTS* 477-78 (1982). Farnsworth does not believe that rigorous adherence to or distinction between "construction" and "interpretation" would be fruitful.

<sup>228</sup> *Id.* at 477.

<sup>229</sup> *Id.*

ing a public policy might enforce the language according to some other "construed" meaning. This often happens with standardized agreements, including insurance contracts. The *Restatement (Second) of Contracts* states that a standardized agreement "is interpreted whenever reasonable, as treating alike all those similarly situated, without regard to their knowledge or understanding of the standard terms of the writing."<sup>230</sup> Under this principle, what the parties think the agreement means is deemphasized relative to other values, such as public policy. The process of "construction" is often disguised as application of well-settled rules of "interpretation," since courts rarely admit they are enforcing an agreement without regard to the parties' meaning. Given the important public policies pervading insurance, it is helpful in the comprehension of cases involving disputes over the meaning of terms in insurance contracts and in the prediction of results in future cases to realize that what courts do and what they say they are doing are often two different things. This is reality; no suggestion is made here that there is anything wrong with this practice.

Since it is unlikely that a reader will ever be involved in a case when the contract language and the factual context are identical to a previously decided case, little can be said for a detailed discussion of cases interpreting insurance contract language. Although these cases are vitally important to lawyers responsible for drafting insurance forms, no lawyer who drafts forms relies on a survey article for recent developments in insurance contract interpretation. Accordingly, this discussion merely provides a quick overview of what Kansas courts are doing in this area.

### 1. "Arising Out of the Ownership, Maintenance, or Use" of a Vehicle

One phrase that has been the subject of frequent litigation is found in all ordinary automobile insurance policies. Such policies, including the two at issue in *Farm Bureau Mutual Insurance Co. v. Evans*,<sup>231</sup> provide coverage for injury "arising out of the ownership, maintenance, or use" of the insured vehicle.<sup>232</sup> In *Evans*, three persons were sitting in the back seat of a station wagon parked at a bonfire party.<sup>233</sup> During the party, one of the persons with the aid of the other two allegedly threw an explosive device known as an "M-80" out of the rear of the station wagon. The M-80 landed in a glass of beer held by a woman at the party; when the M-80 exploded, the woman suffered extensive injuries. The trial court concluded that the policies in question provided coverage for the woman's injuries because "the automobile was being used as a shelter, a reasonable incident of its use and one reasonably contemplated by the parties to the insurance contract."<sup>234</sup> The insurers appealed.

The court of appeals reversed, applying the rule previously recognized in Kansas that there must be some causal connection between the use of the insured

<sup>230</sup> RESTATEMENT (SECOND) OF CONTRACTS § 211(2) (1981).

<sup>231</sup> 7 Kan. App. 2d 60, 637 P.2d 491 (1981).

<sup>232</sup> The court's opinion summarizes the law on this question. See 7 Kan. App. 2d at 62-63, 637 P.2d at 493-94. See generally R. KEETON, *supra* note 29, at 274-78.

<sup>233</sup> The vehicle was insured under a policy sold by Farm Bureau Mutual Insurance Company. One of the persons also had insurance on a separate vehicle, purchased from Farmers Insurance Company, Inc. The question at trial was whether the two policies provided coverage for any of the three persons. 7 Kan. App. 2d at 61, 637 P.2d at 493.

<sup>234</sup> *Id.*

vehicle and the injury.<sup>235</sup> The court found no such causal connection: the use of the vehicle “did not causally contribute to Karen’s injuries anymore than it would have if one of the occupants . . . had shot her with a firearm.”<sup>236</sup> Plaintiff contended that causation did exist, since the M-80 was lit inside the vehicle and the lighting might have been more difficult if no shelter were available. The appeals court disagreed. It reasoned that this was “so remote that it does not furnish the necessary causal relationship between the use of the car and her injuries.”<sup>237</sup>

## 2. “Full and Valid Title”

*Heshion Motors, Inc. v. Trinity Universal Insurance Co.*,<sup>238</sup> involved an insurer’s appeal from a declaratory judgment that its policy provided coverage for a motor vehicle stolen from the policyholder by means of false pretenses. The issue was whether the insured had “full and valid title” prior to the loss of the automobile within the meaning of the policy.

Heshion agreed to purchase a 1973 Jaguar automobile from Faddis Leasing Corporation (Faddis). About a week after the car was delivered to Heshion, a salesman at Heshion permitted two potential purchasers to test-drive the car. The potential purchasers were actually thieves, and the car was later found stripped in Colorado. Heshion paid for the car prior to the theft, but certificate of title was signed, notarized, and delivered to Heshion over a week after the theft.

The policy issued by Trinity to Heshion had a specific “theft by false pretenses” endorsement that excluded coverage unless Heshion had “full and valid title to such covered automobile prior to such loss.” Trinity denied coverage on the ground that Heshion did not have full and valid title on the date of the loss. The trial court ruled that the exclusion with regard to title was ambiguous and that “appellee’s possession, fully paid for, and with the right to sell and the ability to give good title, entitled it to coverage under the policy.”<sup>239</sup>

The court of appeals reversed, reasoning that the insurance coverage was extended “only where there was full and valid title *prior to the loss*.”<sup>240</sup> The court said this clause had two identifiable purposes: first, “to lend stability and certainty” to the determination of whether particular vehicles are covered for theft by deception; and second, to provide for “auditable records to verify ownership” so that premiums charged “may be commensurate with the potential total risk.”<sup>241</sup> The court reasoned: “It does violence to plain words, both as a legal and practical matter to say that the exclusionary clause is ambiguous and uncertain, and therefore subject to construction slanted toward the insured. The clause is clear and precise.”<sup>242</sup> Under this construction, Heshion did not have title prior to the theft of the vehicle. The exclusionary clause was applicable, and

<sup>235</sup> *Id.* at 62-63, 637 P.2d at 493-94.

<sup>236</sup> *Id.* at 63, 637 P.2d at 494.

<sup>237</sup> *Id.* at 63-64, 637 P.2d at 494.

<sup>238</sup> 229 Kan. 412, 625 P.2d 437 (1981), *modifying* 5 Kan. App. 2d 432, 618 P.2d 327 (1980).

<sup>239</sup> 229 Kan. at 413, 625 P.2d at 438-39.

<sup>240</sup> 5 Kan. App. 2d at 435, 618 P.2d at 330 (emphasis original).

<sup>241</sup> *Id.* at 435-36, 618 P.2d at 330.

<sup>242</sup> *Id.* at 436, 618 P.2d at 330.

Heshion was not covered for the loss.<sup>243</sup> The supreme court accepted review and endorsed the court of appeals opinion on the insurance law issue.<sup>244</sup>

### 3. *Physically Able to Perform Livelihood*

In *Swanston v. Cuna Mutual Insurance Society*,<sup>245</sup> the administrator of the estate of Raymond Swanston brought an action for benefits under a group credit life insurance policy issued by Cuna through the McConnell Air Force Base Credit Union. It was stipulated in the trial court that the decedent applied for a loan on May 25, 1976, at which time and until his death fifteen months later he was physically unable to perform the requirements of any job he had previously held. The policy contained a clause that limited coverage to members of the credit union who were "then physically able to perform, or within a reasonable time to resume, the usual duties of his livelihood." The court of appeals affirmed a summary judgment for the insurer.

The court construed the clause as not requiring that the insured actually be employed at the time or within a reasonable time after the loan was secured; rather, the court read the clause as only requiring physical ability to perform the duties of the borrower's livelihood.<sup>246</sup> Since it was stipulated that Swanston was not able to perform the duties of any previous job he had held, summary judgment for the insurer was proper: to construe the policy otherwise "would . . . run counter to the manifest purpose of the policy provision requiring a minimum level of physical well-being."<sup>247</sup> This purpose directly relates to the fact that this was group insurance: "Bearing in mind that this was *group* life insurance where the usual life insurance physical examination is not required, it seems readily apparent that the company sought some minimum level of physical well-being to be exhibited by a credit union member before the company would assume the risk."<sup>248</sup>

### 4. *"Business Pursuits"*

In *Krings v. Safeco Insurance Co. of America*,<sup>249</sup> the court interpreted a standard exclusion in a homeowner's policy for "bodily injury or property damage arising out of business pursuits of any insured except activities therein which are ordinarily incident to non-business pursuits."<sup>250</sup>

Krings was the named insured under a Safeco homeowner's policy which contained the foregoing exclusion. From 1969 until his resignation in 1976, he served as a member of the board of directors of the Kansas Savings and Loan Association (Association), and from 1972 until 1976, he served as the board's chairman. He also owned common stock in the Association; one year's purchases exceeded \$320,000. After the Association went into receivership in 1977, Krings

<sup>243</sup> *Id.*

<sup>244</sup> 229 Kan. at 415, 625 P.2d at 440. The court corrected a portion of the court of appeals' opinion dealing with transferring title to a motor vehicle. This required remanding the case to the trial court for further proceedings.

<sup>245</sup> 7 Kan. App. 2d 28, 636 P.2d 1368 (1981).

<sup>246</sup> *Id.* at 30, 363 P.2d at 1370.

<sup>247</sup> *Id.*

<sup>248</sup> *Id.* (emphasis in original).

<sup>249</sup> 6 Kan. App. 2d 391, 628 P.2d 1071 (1981).

<sup>250</sup> *Id.* at 393, 628 P.2d at 1073.

was sued in five separate lawsuits as a result of his activities with the Association. He wrote Safeco demanding defense of these lawsuits under the terms of his homeowner's policy, but Safeco refused on the ground that there was no coverage due to the "business pursuits" exclusion. The trial court sustained Safeco's motion for summary judgment; Krings appealed, and the court of appeals affirmed, adopting the trial court's Memorandum Decision as its own.

The court of appeals approved a New York test for determining which activities are excluded under a business pursuits clause. Under this test, a "business pursuit" has two elements: (1) continuity—there must be a "customary engagement or a stated occupation"; and (2) a profit motive—the activity must be "a means of livelihood, gainful employment, means of earning a living, procuring subsistence or profit, commercial transactions or engagements."<sup>251</sup> The court of appeals agreed with the trial court that Krings' service as a director of the Association "was a regular activity engaged in with a profit motive."<sup>252</sup>

Applying the principle that intention of the parties to a contract of insurance is based on "what a reasonable person in the position of the insured would have understood the words to mean,"<sup>253</sup> the court concluded that since Krings had been in the insurance business for over forty years, a reasonable person in Krings' shoes would have understood that insurance companies sell different policies for the activities in which he was engaged.<sup>254</sup> Further, the court found nothing inherently ambiguous about the business pursuits exclusion.<sup>255</sup> Accordingly, Krings' homeowner's policy did not cover possible liability for his activities as director of the Association.

##### 5. "Pre-existing Illness"

Many health insurance policies contain a provision limiting coverage to losses resulting from sickness first manifesting itself after the effective date of the policy. Exact terminology varies, but the purpose of such language is uniformly to deny coverage for loss caused by pre-existing illnesses. Such provisions have been the subject of considerable litigation in Kansas and elsewhere.<sup>256</sup>

In *St. Francis Hospital and Medical Center v. Baldwin*,<sup>257</sup> the insured purchased on March 1, 1977, a health insurance policy from American States Insurance Company (American States) which limited coverage to "sickness first manifesting itself after the effective date of this policy and while this policy is in force." The insured first detected a small tumor on her left arm in 1962, but doctors—including American States' doctor who examined her prior to March 1, 1977—advised her that no treatment was necessary unless the tumor changed size or caused her discomfort. In the fall of 1977, the tumor grew and began to cause pain. The insured, on the advice of her physician, had the tumor surgically removed.

<sup>251</sup> 6 Kan. App. 2d at 393-94, 628 P.2d at 1074 (quoting *Fadden v. Cambridge Mutual Fire Ins. Co.*, 51 Misc. 2d 858, 274 N.Y.S.2d 235 (1966), *aff'd*, 27 App. Div. 2d 487, 280 N.Y.S.2d 209 (1967)).

<sup>252</sup> 6 Kan. App. 2d at 394, 628 P.2d at 1074.

<sup>253</sup> *Id.* at 395, 628 P.2d at 1075 (quoting *Gowing v. Great Plains Mutual Ins. Co.*, 207 Kan. 78, syl. ¶ 2, 493 P.2d 1072 (1971)).

<sup>254</sup> *Id.* at 395, 628 P.2d at 1075.

<sup>255</sup> *Id.*

<sup>256</sup> *See, e.g.*, *Bishop v. Capitol Life Ins. Co.*, 218 Kan. 590, 545 P.2d 1125 (1976); *McDaniel v. State Farm Mut. Ins. Co.*, 3 Kan. App. 2d 174, 591 P.2d 1094 (1979).

<sup>257</sup> 6 Kan. App. 2d 124, 626 P.2d 1229 (1981).



American States refused to pay her medical expenses, claiming that the tumor pre-existed the issuance of the insurance policy.

The court of appeals applied the rule articulated in *Southards v. Central Plains Ins. Co.*<sup>258</sup> that "the origin or inception of a sickness or disease" within the meaning of the requirement in a health insurance policy that the illness be contracted after the policy's effective date "is that point in time when the disease becomes manifest or active or when there is a distinct symptom or condition from which one learned in medicine can diagnose the disease."<sup>259</sup> In the court's view, the insured's tumor was "inactive and dormant" at the effective date of the policy and did not become "active and a sickness" until after the effective date.<sup>260</sup> Accordingly, American States was required to reimburse the insured's medical expenses.<sup>261</sup>

#### 6. "Principal Wage Earner"

In *Anderson v. Nationwide Life Insurance Company*,<sup>262</sup> the court of appeals interpreted the phrase "principal wage earner."

Defendant Nationwide offered a group accident insurance policy to plaintiff through her employer. The policy insured the life of plaintiff's husband, who died after the policy became effective. Three conditions had to be fulfilled before benefits could be paid upon the death of plaintiff's spouse, one of which was that the decedent be an "eligible dependent" as defined in the policy. "Eligible dependent" was defined as an insured spouse "who is not the principal wage earner in the family unit." The policy provided no definition of "principal wage earner." Nationwide contended that the plaintiff's husband was the principal wage earner, and therefore the plaintiff was not entitled to any benefits upon his death. The trial court granted plaintiff's motion for summary judgment, finding that the term "principal wage earner" was ambiguous and that decedent was not the principal wage earner.

The court of appeals agreed that the meaning of principal wage earner was not self-evident, citing Nationwide's reference to statutory and secondary sources articulating "several possible definitions."<sup>263</sup> The court also noted that Nationwide had not provided plaintiff "with information at the time she applied for the policy to guide her in assessing whether or not the decedent was an eligible dependent spouse."<sup>264</sup> Further, Nationwide had concluded that decedent was the principal wage earner on the basis of the couple's 1976 tax returns which showed that decedent earned only \$400 more than plaintiff during the year. The court labeled this "unfair," since Nationwide "had not earlier informed plaintiff that it would use this method to establish eligibility."<sup>265</sup> Given the ambiguity, the court of appeals affirmed the trial court's preference for "the interpretation most favorable to the insured," meaning an interpretation of the policy in favor of

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<sup>258</sup> 201 Kan. 499, 441 P.2d 808 (1968).

<sup>259</sup> *Id.* at 501, 441 P.2d at 811.

<sup>260</sup> 6 Kan. App. 2d at 126, 626 P.2d at 1231-32.

<sup>261</sup> *Id.* at 127, 626 P.2d at 1232.

<sup>262</sup> 6 Kan. App. 2d 163, 627 P.2d 344 (1981).

<sup>263</sup> *Id.* at 166-67, 627 P.2d at 346-47.

<sup>264</sup> *Id.* at 167, 627 P.2d at 347.

<sup>265</sup> *Id.*

plaintiff.<sup>266</sup>

### 7. "Temporary Residence"

In *Winsor v. Hartford Fire Insurance Company*,<sup>267</sup> plaintiff sought to recover for a theft loss under a homeowner's policy issued by Hartford. Plaintiff purchased a policy of insurance for residential premises he owned in which his widowed mother and son resided. Plaintiff also rented an apartment in which he stayed overnight at least forty-eight weeks a year. He listed the residential premises as his permanent address on his income tax returns, voter registration, and other documents and accounts, and he kept all his permanent records there. However, he essentially "resided" in the apartment, listing it as his residence in the telephone directory. During the policy period, plaintiff's apartment was burglarized, and plaintiff sought to recover the loss from Hartford. Hartford denied coverage on the ground that the policy excluded coverage for loss "away from the described premises of . . . property at any location owned, rented or occupied by an insured, except while an insured is temporarily residing thereat. . . ." <sup>268</sup> The trial court granted summary judgment for plaintiff, and Hartford appealed.

After reviewing dictionary definitions of "temporary" and "permanent" and discussing several cases interpreting these words, the court opined that "the plain and ordinary meaning of the term [temporary residence] as used in the policy for theft coverage has reference to a place of abode away from the insured premises used by the insured occasionally or seasonally on a limited short-term basis. It does not include another residence on a full-time basis over a protracted and indefinite period of time."<sup>269</sup> Accordingly, the trial court was reversed: the court of appeals held that the plaintiff was not temporarily residing in the apartment within the meaning of the policy, and thus it did not cover his loss.<sup>270</sup>

### 8. Care, Custody or Control Exclusion

*Topeka Railway Equipment, Inc. v. Foremost Insurance Company*<sup>271</sup> involved the interpretation of an exclusionary clause. Topeka Railway, whose business is modifying and repairing railroad cars, received for modification a number of cars owned by the United States government. The cars were delivered to Topeka Railway at Forbes Air Force Base, where Topeka Railway was a permissive user of the tracks. While at Forbes, two of the cars accidentally collided and were damaged. The cars were under the control of the insured after they entered the boundaries of the Base, and they were moved about at the Base by employees of the insured. After the completion of the modification work, the cars were parked only for the period of time necessary for the United States government to retrieve them.

Foremost sold a policy of insurance to Topeka Railway which included a "broad form" property damage endorsement, which in turn contained a so-called "care, custody or control exclusion." Foremost relied upon three parts of the ex-

<sup>266</sup> *Id.* at 167-68, 627 P.2d at 348.

<sup>267</sup> 6 Kan. App. 2d 397, 628 P.2d 1076 (1981).

<sup>268</sup> *Id.* at 398, 628 P.2d at 1077.

<sup>269</sup> *Id.* at 401-02, 628 P.2d at 1079.

<sup>270</sup> *Id.* at 402, 628 P.2d at 1079.

<sup>271</sup> 5 Kan. App. 2d 183, 614 P.2d 461 (1980).

clusion to deny coverage to Topeka Railway for the damaged cars. The trial court rejected Foremost's argument concerning two of the three parts, and Foremost did not appeal those determinations.<sup>272</sup> The only issue confronting the court of appeals was whether the "(Y)(1)" exclusion for damage "to property held by the insured for sale or entrusted to the insured for storage or safekeeping" was applicable. The trial court reasoned that the exclusion was ambiguous. Construing it against the insurer, the trial court "held that the insured had physical control of the cars and thus that coverage was excluded by virtue of (Y)(1)."<sup>273</sup>

The court of appeals disagreed that "merely creating a bailment situation is sufficient to bring the exclusionary provision provided for in (Y)(1) into play."<sup>274</sup> The court reasoned that "the primary reason for creation of the bailment was to carry out the purpose of the contract—to modify and repair the cars. The storage or safekeeping of the cars was only incidental to the bailment. . . ."<sup>275</sup> If the insurer had intended to exclude coverage for any bailment, "most of the broad form property damage endorsement language would be surplus."<sup>276</sup> The court reversed the trial court's judgment for the insurer, holding that the exclusion provided in the policy was not applicable under the facts of this case.<sup>277</sup>

### 9. *Liability for the Costs of Complying with Building Codes*

In *Unified School District No. 285 v. St. Paul Fire and Marine Insurance Co.*,<sup>278</sup> one of the issues concerned the extent of the insurer's liability for tornado damage to a high-school building and school bus garage. The two insurers who had issued policies to the school district argued that their liability should not include any costs of repair necessary to bring the structures into compliance with the Uniform Building Code. The policies contained two provisions purporting to exclude coverage for such costs.<sup>279</sup> The court of appeals agreed with the trial court that these exclusions created an ambiguity because the coverage clauses purported to insure the district's structures "as school facilities, facilities known to be subject to the Building Code."<sup>280</sup> The court construed the policies against the insurers, and

<sup>272</sup> Foremost's argument that the loss was subject to the exclusion for "property . . . owned by or while on premises owned by or rented to the insured" was rejected since Topeka Railway neither owned nor rented the tracks at Forbes. Foremost also argued that the loss occurred to property "upon which operations are being performed by or on behalf of the insured at the time of the property damage arising out of such operations," but the trial court found that the damage did not occur or arise out of any operation or work for which the cars were delivered to the insured. *Id.* at 185, 614 P.2d at 463.

<sup>273</sup> *Id.*

<sup>274</sup> *Id.* at 186, 614 P.2d at 463.

<sup>275</sup> *Id.* at 186, 614 P.2d at 464.

<sup>276</sup> *Id.* at 187, 614 P.2d at 464-65.

<sup>277</sup> *Id.* at 188, 614 P.2d at 465.

<sup>278</sup> 6 Kan. App. 2d 244, 627 P.2d 1147 (1981).

<sup>279</sup> The policies insured plaintiff "to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair." Likewise, the replacement cost endorsement attached to the policies provided:

3. This Company shall not be liable under this endorsement for any loss—

(a) Occasioned by enforcement of any local or state ordinance or law regulating the construction, repair or demolition of buildings unless such liability has been specifically assumed under this policy.

6 Kan. App. 2d at 251, 627 P.2d at 1153.

<sup>280</sup> *Id.* at 252, 627 P.2d at 1152.

the insurers were held to have "assumed liability for the costs of complying with that Code upon loss."<sup>281</sup> In addition, the court approved the trial court's conclusion that the limitations on liability for such costs contained in the policies were void and unenforceable as against public policy.<sup>282</sup>

### 10. *Some Observations*

Can any generalizations be made about judicial interpretation of specific words and phrases? Of the nine cases where the meaning of words or phrases was disputed, insurers won five and insureds won four. There is no basis for concluding that either insurers or insureds have some inherent advantage in this kind of dispute.

As for the principles of interpretation, nothing earth-shattering emerged. When possible, policies are construed to give effect to the intention of the parties.<sup>283</sup> Ambiguities, where they exist, are still construed against the drafter, i.e., the insurer.<sup>284</sup> Limitations on coverage must appear in clear and unambiguous language.<sup>285</sup> Words retain the meaning that a reasonable person in the position of the insured would presume.<sup>286</sup> When a reasonable person standing in the place of the insured would give words their plain and ordinary meaning, words are given that meaning. This is but another way of saying that when there is no ambiguity, there is nothing to be interpreted, and the words are given their "everyday commonly accepted meaning."<sup>287</sup> The construction of a contract of insurance remains a question of law to be decided by the court.<sup>288</sup>

There are still other "maxims" that remain as true as ever. Insurers with more foresight about situations that could arise and who draft against such contingencies fare better than insurers with less foresight. Litigation remains risky and expensive, even for those with powerful foresight. Close cases should be settled.

## IV. AUTOMOBILES

We have so many automobiles, and we crash them into other automobiles, objects, and people so frequently, that recent developments concerning insurance law and automobiles must be an independent subject. Automobile insurance law in Kansas arises principally under two statutes: the Kansas Automobile Injury Reparations Act (KAIRA),<sup>289</sup> and the Kansas uninsured motorist statute.<sup>290</sup>

### A. *The KAIRA*

#### 1. *Legislative Developments*

In each legislative session during the survey period, a number of changes were

<sup>281</sup> *Id.*

<sup>282</sup> *Id.* at 251-52, 627 P.2d at 1153-54.

<sup>283</sup> *American Media, Inc. v. Home Indemnity Co.*, 232 Kan. 737, 658 P.2d 1015 (1983) (quoting *Mah v. United States Fire Ins. Co.*, 218 Kan. 583, 586-87, 545 P.2d 366, 369 (1976)). A good summary of the rules of interpretation is contained in *Mah* and is quoted in *American Media*.

<sup>284</sup> *E.g.*, *Fancher v. Carson-Campbell, Inc.*, 216 Kan. 141, 146, 530 P.2d 1225, 1230 (1975).

<sup>285</sup> *E.g.*, *Goforth v. Franklin Life Ins. Co.*, 202 Kan. 413, 417, 449 P.2d 477, 481 (1969).

<sup>286</sup> *E.g.*, *Casey v. Aetna Casualty & Surety Co.*, 205 Kan. 495, 499, 470 P.2d 821, 826 (1970).

<sup>287</sup> *Id.* at 499, 470 P.2d at 826.

<sup>288</sup> *E.g.*, *Scott v. Keever*, 212 Kan. 719, 721, 512 P.2d 346, 348-49 (1973).

<sup>289</sup> KAN. STAT. ANN. § 40-3101 to -3121 (1981).

<sup>290</sup> KAN. STAT. ANN. § 40-284 (1981).

made in the KAIRA.<sup>291</sup> Senate Bill 371, which passed the 1981 legislature and became effective on January 1, 1982, embodied the most significant of these changes. As introduced, the principal purpose of Senate Bill 371 was to raise the minimum limits of liability coverage.<sup>292</sup> As passed, the bill contained amendments added on the floor of the House which permit insurers to insert eight specific exclusions of coverage in liability policies.<sup>293</sup> Presumably, the bill was amended to undo the effect of *DeWitt v. Young*,<sup>294</sup> when the supreme court struck down household and garage shop exclusions contained in many standard automobile policies and announced a rule that *any* exclusion to the statutorily required minimum coverage is invalid.<sup>295</sup>

Some of the eight exclusions involve situations where the insured will own or will have recourse to other coverage,<sup>296</sup> but two of the exclusions are more significant. One is section 3107(i)(6) of chapter 40 of the Kansas Statutes, which authorizes an insurer to include a provision prohibiting stacking of liability coverages.<sup>297</sup> The other is the household exclusion in section 3107(h)(1) of chapter 40, which permits an insurer to exclude coverage for bodily injury to any insured or family member of an insured residing in the same household. The effect of such an exclusion is to prevent an insured and members of the insured's family who are injured in the family automobile from recovering under their liability coverage. As discussed in the next section, this exclusion has an important nexus with the doctrine of interspousal tort immunity and the uninsured motorist statute.

## 2. The Household Exclusion and Interspousal Immunity

In *DeWitt v. Young*,<sup>298</sup> the supreme court invalidated the standard household exclusion found in many automobile liability policies. One year earlier, the supreme court held in *Nocktonick v. Nocktonick*<sup>299</sup> that an unemancipated minor

<sup>291</sup> In 1981, KAN. STAT. ANN. § 40-3104 was amended to permit the director of vehicles to suspend the license of a motor vehicle owner who does not maintain financial security in circumstances when someone other than the owner is driving the vehicle at the time of the accident. 1981 Kan. Sess. Laws ch. 197, § 1. In the same session, minor changes were made in KAN. STAT. ANN. § 40-3118 concerning suspension of registration of a vehicle when the owner does not maintain continuous financial security. 1981 Kan. Sess. Laws ch. 197, § 1. More substantial changes in the same section were made in the 1982 legislative session. 1982 Kan. Sess. Laws ch. 206, § 1.

<sup>292</sup> The limits for bodily injury or death of one person/bodily injury or death of two or more persons/property damage were increased from \$15,000/\$30,000/\$5000 to \$25,000/\$50,000/\$10,000. KAN. STAT. ANN. 40-3107(e) (1981).

<sup>293</sup> Insurers are authorized by the statute to exclude the following coverages: (1) vehicles rented to others or used to carry persons for a charge other than on a share-the-expenses basis (KAN. STAT. ANN. § 40-3107(h)(1)); (2) vehicles being repaired, serviced, or used by someone in the automobile business, unless the insured is in the automobile business (*Id.* § 40-3107(h)(2)); (3) bodily injury to any insured or family member of an insured residing in the insured's household (*Id.* § 40-3107(i)(1)); (4) damages for which the United States government "might be liable" (*Id.* § 40-3107(i)(2)); (5) damages to property "owned by, rented to, or in charge of or transported by an insured," except a rented residence or private garage (*Id.* § 40-3107(i)(3)); (6) worker's compensation obligations (*Id.* § 40-3107(i)(4)); (7) liability "assumed by an insured under any contract or agreement" (*Id.* § 40-3107(i)(5)); (8) stacking of liability limits when two or more liability policies apply to the same accident (*Id.* § 40-3107(i)(6)).

<sup>294</sup> 229 Kan. 474, 625 P.2d 478 (1981).

<sup>295</sup> *Id.* at 480, 625 P.2d at 483.

<sup>296</sup> For example, one who rents cars to others must have a renter's liability policy. A user of a vehicle who is in the automobile business will probably have liability insurance. See Palmer, *Automobile and Uninsured Motorist Coverages*, 5 J. KAN. TRIAL LAWYERS ASS'N. 11, 13 (Issue No. 2, 1981).

<sup>297</sup> Current rules on stacking generally are summarized at note 413 *infra*.

<sup>298</sup> 229 Kan. 474, 625 P.2d 478.

<sup>299</sup> 227 Kan. 758, 611 P.2d 135 (1980).

child could recover damages in a tort action against a parent for injuries caused by the negligence of the parent in operating an insured motor vehicle. With these two decisions, automobile liability insurers faced the prospect of paying liability insurance proceeds to any household member—with the possible exception of the situation in which one spouse injured the other—who suffered injury in an automobile accident due to the negligence of another household member. The legislature responded to this situation with Senate Bill 371, which authorized insurers to insert the household exclusion in automobile liability policies commencing on January 1, 1982. In the meantime, the celebrated case *Guffy v. Guffy*<sup>300</sup> was working its way to the supreme court. Shortly after Senate Bill 371 was passed, the supreme court in *Guffy* reaffirmed the doctrine of interspousal immunity, which prevents one spouse from maintaining an action against the other for a personal, postnuptial tort.<sup>301</sup>

After *Guffy*, two questions were ready for litigation. First, is a person who is injured in an automobile accident due to the negligence of that person's spouse entitled to recover uninsured motorist benefits pursuant to a liability insurance policy purchased by either spouse on the ground that the negligent spouse is an uninsured motorist as to the injured spouse? Second, is a person who is injured in an automobile accident due to the negligence of a non-spouse member of the injured person's household entitled to recover uninsured motorist benefits pursuant to a household member's liability insurance policy which contains a household exclusion, on the ground that the non-spouse household member is an uninsured motorist as to the injured person? The supreme court answered the first question in *Patrons Mutual Insurance Association v. Norwood*.<sup>302</sup>

Charles Norwood was a passenger in an automobile driven by his wife when an accident occurred causing him personal injury. Under the doctrine of interspousal immunity, Norwood could not sue his wife in tort for damages that would be paid by his wife's liability policy. Therefore, he made a claim under her policy for uninsured motorist protection, arguing that his wife, although insured, was uninsured as to him because of interspousal immunity. Patrons denied his claim, and Norwood sued.

Patrons' denial of Norwood's claim was, interestingly, the key to his argument. The policy defined "insured" as "the named insured [i.e., Maeola Norwood] [and] any relative."<sup>303</sup> The uninsured motorist section of the policy required the company "[t]o pay all sums which the insured [i.e., Charles Norwood] shall be legally entitled to recover as damages from the owner or operator of an uninsured automobile" causing injury to the insured. "Uninsured automobile" was defined as including an automobile "with respect to which there is . . . [an] insurance policy applicable at the time of the accident but the company writing the same denies coverage thereunder. . . ."<sup>304</sup> Because Patrons "denied coverage" under

<sup>300</sup> 230 Kan. 89, 631 P.2d 646 (1981).

<sup>301</sup> In *Guffy*, the court noted that its decision "does not deal with intentional torts." *Id.* at 97, 631 P.2d at 651. In two recent decisions, the court has held that an exception exists to the doctrine of interspousal immunity for "willful and intentional torts." *Stevens v. Stevens*, 231 Kan. 726, 728, 647 P.2d 1346, 1348 (1982); *Ebert v. Ebert*, 232 Kan. 502, 503, 656 P.2d 766, 767 (1983).

<sup>302</sup> 231 Kan. 709, 647 P.2d 1335 (1982).

<sup>303</sup> *Id.* at 710, 647 P.2d 1336.

<sup>304</sup> *Id.* at 711, 647 P.2d 1336.

the policy issued to his wife when Norwood filed his claim, Norwood argued that his wife was an uninsured motorist as to him.

Section 284 of chapter 40 of the Kansas Statutes provides that each automobile liability insurance policy issued in Kansas shall contain a provision reimbursing the insured for "part or all sums which the insured . . . shall be *legally* entitled to recover as damages from the uninsured owner or operator of a motor vehicle."<sup>305</sup> The trial court reasoned that the words "legally entitled to recover" do not mean that the insurer "stands in the tortfeasor's stead, but simply that the plaintiff must be able to establish fault on the part of the tortfeasor."<sup>306</sup> Under the trial court's approach, adopted in some jurisdictions,<sup>307</sup> the plaintiff need only establish negligence and damages; the existence of "a defense of limitations or some form of statutory immunity" would not mean that the plaintiff was not "legally entitled to recover."<sup>308</sup> Consequently, the trial court concluded that Norwood would be entitled to uninsured motorist benefits, assuming he could establish that the fault of his wife caused his injuries. Patrons appealed.

The supreme court, relying on some of its earlier decisions, described the purpose of the uninsured motorist statute as "afford[ing] the same protection to a person injured by an uninsured motorist as he or she would have enjoyed if the offending motorist had carried liability insurance."<sup>309</sup> Given this purpose, the court reasoned that Norwood's claim should be denied, since "[u]nder the doctrine of interspousal immunity he could not have recovered from his wife regardless of whether she carried liability insurance."<sup>310</sup>

As the court acknowledged, it was not inevitable that the phrase "legally entitled to recover" should require the injured insured to prevail over any and all defenses the uninsured motorist would possess if the suit were against that person instead of the insurer.<sup>311</sup> The statutory language is ambiguous and "should arguably be construed strictly against the insurer."<sup>312</sup> Moreover, as the court noted, earlier Kansas decisions contain some support for interpreting section 284 of chapter 40 as requiring the plaintiff to establish only the fault of the uninsured motorist to recover under uninsured motorist coverage.<sup>313</sup> Without attempting to answer each of these propositions, the court candidly stated that the case turned upon public policy: *Guffy* balanced "the public policy of providing liability insurance coverage for all drivers against that of preserving the peace and harmony of the home" and "came down on the side of interspousal immunity."<sup>314</sup> In the court's view, Norwood was trying to circumvent the policy choice made in *Guffy*; the court did not permit him to do so. If *Guffy* represents good public policy, *Norwood* is correctly decided.<sup>315</sup> Since *Guffy* places Kansas in

<sup>305</sup> KAN. STAT. ANN. § 40-284(a) (1981) (emphasis added).

<sup>306</sup> 231 Kan. at 712, 647 P.2d at 1338.

<sup>307</sup> *Id.* at 715, 647 P.2d at 1339.

<sup>308</sup> *Allstate Ins. Co. v. Elkins*, 77 Ill. 2d 384, 390-91, 396 N.E.2d 528, 531 (1979).

<sup>309</sup> 231 Kan. at 716, 647 P.2d at 1340.

<sup>310</sup> *Id.*

<sup>311</sup> *Id.* at 713-14, 647 P.2d at 1338.

<sup>312</sup> *Id.* at 714, 647 P.2d at 1338.

<sup>313</sup> *Id.* at 713, 647 P.2d at 1337-38.

<sup>314</sup> *Id.* at 716, 647 P.2d at 1340.

<sup>315</sup> "If" is a big word. The court said: "If the purpose of the uninsured motorist statute is to afford the same protection to a person injured by an uninsured motorist as he or she would have enjoyed if the offending motorist had carried liability insurance, it makes sense to deny Charles Norwood's claim." 231 Kan. at 716, 647 P.2d at 1340.

company with a "dwindling minority" of jurisdictions that adhere to the doctrine of interspousal immunity, *Guffy* did not escape criticism.<sup>316</sup> Its critics will find little to commend *Norwood*.

Nevertheless, it is important to note that *Norwood* did not address the second question identified earlier: whether the presence of a household exclusion in a liability policy renders the tortfeasor an uninsured motorist. In *Norwood*, whether the insurance policy contained a household exclusion was irrelevant, since there was not even an actionable claim against the wife. Thus, the holding of *Norwood* is actually quite limited. Indeed, one can argue consistently with *Norwood* that a non-spouse member of a household<sup>317</sup> who is injured by another household member is entitled to uninsured motorist benefits where the policy contains a household exclusion, so long as the injured member of a household can sue the injuring household member in tort. Of course, if the supreme court in the future reverses *Nocktonick* and reinstates the doctrine of parental immunity in its totality, as the court intimated in *Guffy* it might do,<sup>318</sup> then a child would be barred from uninsured motorist benefits under the logic of *Norwood*. Yet, this would not prevent a member of a household who is not injured by the spouse or the parent from recovering uninsured motorist benefits.

Despite the seeming incongruity of treating spouses and possibly children differently from other household members regarding the availability of uninsured motorist benefits, arguably this is what the legislature intended. For example, in section 3107(f) of chapter 40 of the Kansas Statutes, the legislature declared that a motorcyclist who rejects personal injury protection benefits does not cause his "motorcycle or motor-driven cycle to be an uninsured motor vehicle." There is no similar language in the KAIRA declaring that the presence of a household exclusion in an automobile liability insurance policy does not render household members "uninsured motorists" as to each other.<sup>319</sup> The resolution of this issue must await a future case. Ultimately, the entire area of intrafamily tort liability must be clarified. This is an appropriate task for the legislature.<sup>320</sup>

### 3. PIP Benefits

Under the KAIRA, every policy of liability insurance issued by an insurer to a Kansas resident must include "personal injury protection benefits," or "PIP benefits."<sup>321</sup> There are six categories of PIP benefits, two of which are "disability benefits"<sup>322</sup> and "survivors benefits."<sup>323</sup> Disability benefits are intended to assist

<sup>316</sup> See Note, *Torts—Interspousal Immunity in Kansas: A Vestige of a Bygone Era—Guffy v. Guffy*, 30 KAN. L. REV. 611 (1982).

<sup>317</sup> In *Guffy*, the supreme court stated that the premise on which *Nocktonick* was based is no longer valid, given the intervening enactment of legislation authorizing insurers to incorporate household exclusions in automobile liability insurance policies. See 230 Kan. at 96, 631 P.2d at 650-51.

<sup>318</sup> 230 Kan. at 96, 631 P.2d at 650. Presumably, any such reversal in *Nocktonick* will not extend to intentional torts. See note 301 *supra*.

<sup>319</sup> Palmer, *supra* note 296, at 12-13.

<sup>320</sup> Bills on intrafamily tort liability were introduced in the last two legislative sessions. House Bill 2614, introduced in the 1982 session, would have prohibited any family member from suing another in tort unless the family purchased liability insurance for such claims. The bill went to Committee, but never came up for a house vote. HOUSE JOURNAL 2143 (1982). House Bill 2070, introduced in the 1983 session, would have prohibited an unemancipated minor child from suing his parents in tort. This bill also died in committee. HOUSE JOURNAL 1014 (1983).

<sup>321</sup> KAN. STAT. ANN. § 40-3107(f) (1981).

<sup>322</sup> KAN. STAT. ANN. § 40-3103(b), (q) (1981).



the injured person who loses earnings because he cannot work; survivors benefits are intended to assist the dependent who loses the support of the earnings of a person killed in an automobile accident. The amount of benefits depends upon the injured person's, or the decedent's, "monthly earnings." The application of the statutory formula for determining earnings resulted in considerable litigation during the survey period.

*a. Computing Monthly Earnings of an Unemployed Person Who Has Been Previously Employed*

Both disability benefits and survivors benefits are derived from the injured or deceased person's "monthly earnings." "Monthly earnings" are calculated pursuant to the formula in section 3103(l) of chapter 40 of the Kansas Statutes. For a person unemployed or not regularly employed, monthly earnings are one-twelfth of "the anticipated annual earnings."<sup>324</sup> To compute the anticipated annual earnings of an unemployed person who has previously been employed, the insurer is instructed by the statute to "average the annual compensation of such person for not to exceed five (5) years preceding the year of injury or death, during which such person was employed."<sup>325</sup> The supreme court granted review in *Coe v. Security National Insurance Co.*<sup>326</sup> "to settle the question of how to calculate the 'anticipated annual earnings' of an unemployed person who has been previously employed."<sup>327</sup>

The supreme court approved the following four-step method of computing "average anticipated earnings":

1. Ignore the year of injury or death.
2. Ignore any of the five preceding years during which the decedent was not employed and had no income.
3. Total the annual compensation of the remaining years (regardless of whether the decedent worked a full or part year, or received income from regular or temporary work or both).
4. Divide this total by the number of remaining years. The resulting figure is "average anticipated earnings."<sup>328</sup>

The court candidly conceded that "factual situations can be conjured up which may result in inequity," but it opined that the approved formula "seems as fair to all concerned as can be gleaned from the directions of the statutory language employed by the legislature."<sup>329</sup>

Justice Herd dissented, stating in a very brief opinion that he would disregard in this case two of the five preceding years during which the decedent had only engaged in temporary work. In those years, she earned considerably less than in the three other years during which she worked full-time as a state employee. Justice Herd's computation would have resulted in a larger "anticipated annual earnings" figure.<sup>330</sup>

<sup>323</sup> KAN. STAT. ANN. § 40-3103(x) (y) (1981).

<sup>324</sup> KAN. STAT. ANN. § 40-3103(l), (z).

<sup>325</sup> *Id.*

<sup>326</sup> 228 Kan. 624, 620 P.2d 1108 (1980).

<sup>327</sup> *Id.* at 627, 620 P.2d at 1111.

<sup>328</sup> 228 Kan. at 627, 620 P.2d at 1111.

<sup>329</sup> *Id.* at 629, 620 P.2d at 1112.

<sup>330</sup> *Id.* at 632, 620 P.2d at 1114 (Herd, J., dissenting).

Justice Herd's brief opinion did not provide a rationale for his alternative computation, but he probably perceived that the court's computation formula could result in gross inequity in some circumstances. The court of appeals offered such an example: a law student accepts an offer of employment at \$17,000 per year but is disabled in an accident before commencing work. If the student had no employment during the preceding five years, the student would have "anticipated annual earnings" of \$17,000 annually and would be entitled to the maximum monthly disability payment of \$650 per month. However, if the student earned \$1000 a year during the preceding five years in part-time jobs, under the supreme court's approach, that student would receive under the majority's formula only \$83.33 per month in disability benefits.<sup>331</sup> This is what happened in *Coe*, albeit to a lesser extent. By working part-time in two of the five years, the decedent's anticipated annual earnings were reduced. Justice Herd wanted to ignore the two part-time years. The court of appeals wanted to "annualize" her earnings during those two years, reasoning that this was more consistent with legislative intent.<sup>332</sup> The supreme court's answer was to apply the statute literally. In *Coe* and in other cases, the result will be arguably unfair, but there is no doubt that, applied literally, the statute reads as the supreme court applied it.

Plainly, legislative action to clarify section 3103(l) would be appropriate. Modifying the statute so that annual compensation is averaged for those years, not to exceed five years, during which the disabled person was *regularly* employed would correct the problem in *Coe* and most other cases. Indeed, it is likely that this is what the legislature intended when it first enacted the statute.

*b. Computing Disability Benefits Where The Insured Is Not Employed Year-Round*

In *Armocost v. State Farm Mutual Automobile Insurance Co.*,<sup>333</sup> the supreme court considered whether plaintiff was entitled to PIP disability benefits under her automobile insurance contract with State Farm for the summer months during which she did not work. Plaintiff, a school teacher, was under contract to teach from August 30, 1979, through June 6, 1980, and was paid in twelve monthly installments.

Plaintiff was injured in an automobile accident on March 10, 1980. She was unable to resume work until well over a year later. State Farm acknowledged that it was liable to pay PIP disability benefits for a one-year period beginning on the date of the accident, but it denied any obligation to pay benefits for the period from June 5 to August 28, 1980, when plaintiff was not obligated to teach and did not intend, by her own admission, to seek other employment. The trial court entered a summary judgment for State Farm, but the supreme court reversed.

The supreme court reasoned that plaintiff was a "regularly employed" person as that term is used in section 3103(l).<sup>334</sup> Her injury was, in the language of section 3103(b), "the proximate cause of [her] inability to engage in available and appropriate gainful activity," notwithstanding her intent not to engage in

<sup>331</sup> *Coe v. Security National Ins. Co.*, 5 Kan. App. 2d 176, 179, 614 P.2d 455, 459, *aff'd in part, rev'd in part*, 228 Kan. 624, 620 P.2d 1108 (1980).

<sup>332</sup> 5 Kan. App. 2d at 181, 614 P.2d at 460.

<sup>333</sup> 231 Kan. 276, 644 P.2d 403 (1982).

<sup>334</sup> *Id.* at 278, 644 P.2d at 405.

such activity during the summer vacation period.<sup>335</sup> Since she was regularly employed within the meaning of the statute during the period of her vacation from teaching duties, the court held that she was entitled to payment of PIP disability benefits for the summer months.<sup>336</sup>

If one considers only the statute, it is apparent why State Farm chose to litigate. Section 3103(b) seems to contemplate that the disability benefit be provided when there is a "loss of monthly earnings." Since plaintiff arguably had no monthly earnings during the summer when she was on vacation and not working, she had no "loss." Such an argument might have prevailed if the statute did not define "monthly earnings" as one-twelfth of the annual earnings of a regularly employed person.<sup>337</sup> Once it was decided that plaintiff was regularly employed, it followed that she lost "monthly earnings" simply because she lost part of her "annual earnings." The court felt that she should be reimbursed for this loss of earnings, irrespective of whether she was on vacation part of the year or not.

Moreover, the court might have been influenced by the \$650 statutory limitation on the maximum monthly benefit.<sup>338</sup> Given this limitation, it was impossible for plaintiff to be reimbursed for one-hundred percent of her loss (assuming she had no other sources of disability income). When the \$650 limitation is taken into account, the economic issue in the case was whether State Farm must pay plaintiff \$650 for each of two and one-half additional months. By rejecting State Farm's position, the court made it possible for this plaintiff to be reimbursed for a greater portion of her actual loss. In short, the court adroitly maneuvered through sticky statutory language to reach a result consistent with the statute's spirit.

*c. The Availability of Disability Benefits to Unemployed Insureds*

In *Morgan v. State Farm Mutual Automobile Insurance Co.*,<sup>339</sup> the court of appeals considered the circumstances under which an unemployed person is entitled to disability benefits.

The plaintiff in *Morgan* had been unemployed for five years prior to an automobile accident in which she was injured. The court of appeals stated that she had "failed to convince the [trial] court that there was a reasonable expectation of future employment"<sup>340</sup> and therefore she was not entitled to PIP disability benefits. The court articulated a four-part test for determining when a claimant is entitled to disability benefits. The claimant must establish (1) inability to engage in "available and appropriate gainful employment" by showing (a) the nature and extent of the injury; (b) that the injury caused the inability to work; and (c) that a "potential employment was accessible, obtainable and commensurate with her skills, educational background, work experience and any other relevant employment criteria"; (2) that regular employment would commence within one year after becoming unable to work; (3) either an actual offer of employment or

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<sup>335</sup> *Id.*

<sup>336</sup> *Id.* at 279, 644 P.2d at 405.

<sup>337</sup> KAN. STAT. ANN. § 40-3103(f) (1981).

<sup>338</sup> KAN. STAT. ANN. § 40-3103(b)(3) (1981).

<sup>339</sup> 5 Kan. App. 2d 135, 613 P.2d 684 (1980).

<sup>340</sup> *Id.* at 140, 613 P.2d at 688.

some other evidence that persuades “the trier of fact that regular employment is a reasonable expectation”; and (4) a reasonable basis for the calculation of anticipated future earnings.<sup>341</sup>

The court of appeals was correct that the KAIRA requires one claiming PIP disability benefits to show “more than a mere hope or desire that employment will be obtained in the future.”<sup>342</sup> Perhaps requiring an unemployed person either to have been regularly employed previously or to have a firm offer of future employment would be an easier test to administer. Nevertheless, the court’s four-part test should provide insurers and insureds with sufficient guidance to resolve most cases without litigation. Moreover, the court’s more flexible test is both fair and consistent with the statute. In the future, there may be cases where, in the language of section 3103(/), there is a “reasonable expectation of regular employment” notwithstanding the absence of prior employment or a present job offer.

*d. Pensions, Social Security Income, and Sole Proprietorship Earnings as “Monthly Earnings”*

Regardless of the specificity with which the legislature defines “monthly earnings,” it is not possible to eliminate all ambiguities. *Bradley v. AID Insurance Co.*,<sup>343</sup> a court of appeals decision, illustrates the complexities inherent in the determination of “monthly earnings.” The deceased, who was killed in an automobile accident, operated a sole proprietorship at a loss for tax purposes. The trial court held that the monthly earnings from which survivor benefits are calculated included the deceased’s pension and social security benefits as well as the gross profits of a used car business that the decedent operated at a loss for tax purposes. The court of appeals held that pension and social security benefits are not “monthly earnings” upon which an award of survivor’s benefits is based.<sup>344</sup> The court declined to announce as a general rule that gross profits can never be used to figure monthly earnings: “we do not agree . . . that there can never be earnings within the meaning of the statute from a sole proprietorship which has operated at a loss for tax purposes.”<sup>345</sup> However, in the circumstances of this case, the court of appeals believed that the plaintiff “failed to meet her burden of proving loss of earnings with reasonable or sufficient certainty.”<sup>346</sup> Accordingly, the court of appeals held that the trial court should not have used gross profits of the decedent’s used car business to calculate lost monthly earnings.<sup>347</sup>

*e. PIP Benefits and the Statute of Limitations*

Section 275 of chapter 40 of the Kansas Statutes provides that an “advance payment or partial payment of damages, predicated on possible tort liability, as an accommodation to an injured person, or on his behalf to others . . . of medical expenses, loss of earnings and other actual out of pocket expenses because of

<sup>341</sup> *Id.* at 142, 613 P.2d at 689.

<sup>342</sup> *Id.* at 140, 613 P.2d at 688.

<sup>343</sup> 6 Kan. App. 2d at 367, 629 P.2d at 720.

<sup>344</sup> *Id.* at 372, 629 P.2d at 724.

<sup>345</sup> *Id.* at 376, 629 P.2d at 727.

<sup>346</sup> *Id.*

<sup>347</sup> *Id.*

an injury . . . property loss or potential claim"<sup>348</sup> is not admissible into evidence as an admission against interest or an admission of liability. However, the statute also provides that "the period fixed for the limitation for the commencement of actions shall commence on the date of the last payment or partial payment made hereunder."<sup>349</sup> In *Lytle v. Pepsi Cola General Bottlers, Inc.*,<sup>350</sup> the question was whether under section 275 the payment by a tortfeasor's insurer to an injured person's insurer to reimburse PIP benefits previously paid to the injured party tolls the two-year statute of limitations for actions in tort.<sup>351</sup>

On May 4, 1977, an employee of the defendant injured the plaintiff in a collision. Defendant's liability carrier settled plaintiff's claim for damages to his car on June 20, 1977. The court reasoned that the payment which tolls the statute of limitations under section 275 must be "a payment made (1) as an accommodation to an injured person, or (2) on his behalf to others."<sup>352</sup> The reason that such payments toll the statute of limitations is to prevent "a party from negotiating with the injured person and making partial payments until the statute of limitations has run and then refusing further negotiation or payment, leaving the injured person without complete recovery."<sup>353</sup>

In a dictum, the court opined that the June 20, 1977, payment tolled the statute of limitations, since "it provided monetary assistance to the plaintiff during the pendency of his claim. It was also an accommodation to him. . . ."<sup>354</sup> However, plaintiff did not file his action against defendant until August 31, 1979. Consequently, plaintiff was forced to argue that the payment by defendant's insurer on April 17, 1978, to his insurer reimbursing PIP benefits paid to plaintiff tolled the statute of limitations. The court rejected this argument, reasoning that the "right of reimbursement . . . is a right that belongs to the PIP insurer . . . [plaintiff] had no interest in the reimbursement funds; they belonged to plaintiff's insurer."<sup>355</sup> Accordingly, the court concluded that the reimbursement "cannot be said to have been made as an accommodation to the plaintiff, since it did not in any way benefit him or assist him monetarily during the pendency of his claim."<sup>356</sup> Further, the court disagreed that reimbursement was "a payment made on [the insured's] behalf," since plaintiff had no liability to his insurer.<sup>357</sup> The court of appeals held that the payment from defendant's insurer to plaintiff's insurer did not toll the statute of limitations, and therefore the statute barred plaintiff's action.<sup>358</sup>

*f. The Requirement to Pay PIP Benefits Promptly*

Section 3310(a) of chapter 40 of the Kansas Statutes provides that PIP benefits are "due and payable as loss accrues, upon receipt of reasonable proof of such loss." Under section 3310(b), PIP benefits are overdue if not paid within thirty

<sup>348</sup> KAN. STAT. ANN. § 40-275 (1981).

<sup>349</sup> *Id.*

<sup>350</sup> 8 Kan. App. 2d 332, 656 P.2d 786 (1983).

<sup>351</sup> KAN. STAT. ANN. § 60-513.

<sup>352</sup> 8 Kan. App. 2d at 335, 656 P.2d at 789.

<sup>353</sup> *Id.* at 337, 656 P.2d at 790.

<sup>354</sup> *Id.* at 335, 656 P.2d at 789.

<sup>355</sup> *Id.* at 336, 656 P.2d at 789.

<sup>356</sup> *Id.* at 337, 656 P.2d at 789.

<sup>357</sup> *Id.*, 656 P.2d at 790.

<sup>358</sup> *Id.*

days after the insurer receives written notice of a covered loss, unless the insured has "reasonable proof to establish that it is not responsible for the payment." Overdue payments accumulate simple interest at the rate of eighteen percent per annum,<sup>359</sup> and the insurer may have to pay reasonable attorneys' fees "if the court finds that the insurer . . . unreasonably refused to pay the claim or unreasonably delayed in making proper payment."<sup>360</sup>

What constitutes reasonable proof of an insured's covered loss by the insured and reasonable proof of the insurer's nonresponsibility was considered in *DiBassie v. American Standard Insurance Co. of Wisconsin*,<sup>361</sup> a court of appeals decision. The court answered these questions as follows:

We hold that an insured has provided "reasonable proof" of his right to recover PIP benefits whenever he furnishes to his insurer a bill for medical treatment which, when viewed with other objective facts furnished to the insurer, shows a clear relation to a covered loss. Stated another way, PIP benefits become due and payable whenever the information known to the insured is such that a reasonable mind would conclude that there is a substantial likelihood that a claimed loss bears a logical connection to a compensable automobile accident.<sup>362</sup>

In *DiBassie*, the court held that the insured had provided "reasonable proof" when he submitted expense records to the insurer and a letter from his attorney stating that the expenses were incurred for injuries suffered in an automobile accident.<sup>363</sup> Because the insurer cited no information within its knowledge that constituted "reasonable proof" of facts relieving it of responsibility for payment,<sup>364</sup> the court held that plaintiff was entitled to interest on the overdue PIP benefits<sup>365</sup> and his attorney was entitled to a reasonable fee.<sup>366</sup>

#### 4. Reimbursement, Subrogation, and Attorney's Fees

In 1977, the supreme court construed section 3113 of chapter 40 of the Kansas Statutes to allow the insurer complete reimbursement of PIP benefits paid to the injured party from any recovery that person might make in a lawsuit against the tortfeasor.<sup>367</sup> Under this construction, the insurer did not share the expenses of recovering the judgment against the tortfeasor. In response to this situation, the legislature repealed section 3113 and replaced it with section 3113a. This statute (1) subrogates a PIP insurer to the damages recovered from a third-party "to the extent duplicative of [PIP] benefits already paid"; (2) gives the insurer a credit against PIP benefits not yet paid; and (3) offsets the insurer's right of subrogation by, first, the percentage of negligence attributable to the insured and, second, a proportionate share of the attorney fees fixed by the court.<sup>368</sup>

One ambiguity in section 3113a concerns the scope of the insurer's subrogation

<sup>359</sup> KAN. STAT. ANN. § 40-3110(b) (1981).

<sup>360</sup> KAN. STAT. ANN. § 40-3111(b) (1981).

<sup>361</sup> 8 Kan. App. 2d at 515, 661 P.2d at 812 (1983).

<sup>362</sup> *Id.* at 519, 661 P.2d at 817.

<sup>363</sup> *Id.* at 520, 661 P.2d at 817-18.

<sup>364</sup> *Id.* at 522, 661 P.2d at 819.

<sup>365</sup> *Id.*

<sup>366</sup> *Id.* at 524, 661 P.2d at 820.

<sup>367</sup> *Eason v. Farmers Ins. Co.*, 221 Kan. 415, 560 P.2d 117 (1977).

<sup>368</sup> KAN. STAT. ANN. § 40-3113a (1981).

right. In *Hall v. State Farm Mutual Automobile Insurance Co.*,<sup>369</sup> the court of appeals considered whether a PIP insurer "has a statutory right of subrogation for all medical benefits paid its insured, or whether its subrogation rights are limited to \$2,000, which is the minimum amount of medical benefits coverage required to be provided in a motor vehicle liability policy pursuant to KAIRA."<sup>370</sup> The provisions of KAIRA yield no clear answer. Section 3113a(b) provides that "the insurer . . . shall be subrogated to the extent of duplicative personal injury protection benefits provided." So, what are PIP benefits? Section 3103(a) defines PIP benefits as "the . . . medical benefits [and five other types of benefits] . . . required to be provided in motor vehicle liability insurance policies pursuant to this act."<sup>371</sup> Section 3103(k) states that "[m]edical benefits' shall mean and include allowances for all reasonable expenses, up to a limit of not less than two thousand dollars" for described medical care.<sup>372</sup> Hall argued that the only medical benefits in the amount of \$2,000 are "required to be provided" by KAIRA; thus the PIP insurer is only subrogated to \$2,000 of medical benefits. State Farm argued that medical benefits and five other *kinds* of benefits are "required to be provided" by the statute, and that the insurer is subrogated to the full amount of each kind of benefit paid to the insured.

The court of appeals agreed with State Farm. It concluded that KAIRA's purpose in granting the right of subrogation is to prevent double recovery by the insured for a loss; limiting the right of subrogation would enable the insured to receive a double recovery. In the court's view, this request would be inconsistent with the purpose of the statute. "Under KAIRA, the parties may contract for PIP medical benefits in excess of the statutory minimum. We hold that PIP medical benefits in excess of the \$2,000 minimum are benefits to which an insurer has a right of subrogation under K.S.A. 40-3113a(b)."<sup>373</sup>

As a matter of statutory interpretation, the question confronting the court was a very close one. The insurance commissioner had interpreted the statute as limiting the insurer's right of subrogation to the statutory minimum,<sup>374</sup> and the House Committee on the Judiciary in 1982 expressed the view that the insurer's subrogation right is limited to the statutory minimum.<sup>375</sup> Yet, the legislature did not pass proposed legislation in 1982 that would have made this clear.<sup>376</sup> The court of appeals felt that the view of a house committee in 1982 regarding the 1977 legislature's intent "carries little weight" and that the insurance commissioner's interpretation was "far from conclusive."<sup>377</sup>

The supreme court denied Hall's petition for review;<sup>378</sup> unless the legislature acts, the insurer's statutory subrogation right is not limited to the minimum PIP coverages. The consequences of this rule are difficult to predict. Injured insureds litigating their claims against tortfeasors may be less willing to settle at low

<sup>369</sup> 8 Kan. App. 2d 475, 661 P.2d 402 (1983).

<sup>370</sup> *Id.* at 477, 661 P.2d at 404.

<sup>371</sup> KAN. STAT. ANN. § 40-3103(a) (1981).

<sup>372</sup> KAN. STAT. ANN. § 40-3103(k) (1981).

<sup>373</sup> 8 Kan. App. 2d 481-82, 661 P.2d at 407.

<sup>374</sup> See generally Brief Amicus Curiae of Insurance Commissioner Fletcher Bell; Appellee's Brief, Appendix, Exhibit 3, *Hall v. State Farm Auto. Ins. Co.*, 8 Kan. App. 2d 475, 661 P.2d 402 (1983).

<sup>375</sup> Appellee's Brief, Appendix, Exhibit 7, *Hall*.

<sup>376</sup> H. 3154, HOUSE JOURNAL 2202 (1982).

<sup>377</sup> 8 Kan. App. 2d 480, 661 P.2d at 406.

<sup>378</sup> *Hall v. State Farm Mut. Auto. Ins. Co.*, No. 54,212 (Kan. May 6, 1983).

amounts, since the insured will have no net recovery unless the settlement exceeds the amount of PIP benefits.<sup>379</sup> Perhaps some insureds will be discouraged from suing the tortfeasor. Insurers may choose to denominate any excess medical coverage purchased by the insured as "PIP Coverage," thereby creating a statutory right to subrogation of all PIP benefits paid the insured. This is not necessarily undesirable: presumably, if insurers can reduce costs by pursuing their subrogation rights, lower prices should be charged insureds for their coverage.

Another ambiguity in the statute concerns the attorneys' fee provision in section 3113(e) of chapter 40, which essentially requires the insurer to pay a proportionate share of the legal expenses incurred by the insured in obtaining a recovery against a tortfeasor.<sup>380</sup> In *Ballweg v. Farmers Insurance Co.*,<sup>381</sup> the supreme court considered two cases, consolidated for purposes of appeal, where one company insured both the tortfeasor and the injured party. PIP benefits were paid to the injured insureds, and each injured insured commenced litigation against the tortfeasor. In each case, the parties reached a settlement, one of the terms of which was reimbursing the insurer for PIP benefits. In each case, the attorneys representing the injured insured claimed that the insurer, pursuant to section 3113a(e), owed him a proportionate share of the attorneys' fees attributable to recovering the PIP benefits. Each insurer argued that it needed no assistance from the insured's attorney to collect the reimbursement for the PIP benefits, since the insurer also covered the tortfeasor. The court rejected the insurer's argument: "[W]e find no exception mentioned which would justify withholding payment of reasonable attorney fees in cases where a single insurance company represents all parties."<sup>382</sup>

After *Ballweg*, it should have been clear that the supreme court had mandated that the act be applied in accordance with its plain language. If it was not clear than, it is now. In *Johnston & Johnston, P.A. v. Gulf Insurance Co.*,<sup>383</sup> the court of appeals held that the insured's attorney was entitled to a fee from the PIP benefits recovery for the insurer, even though the insured's attorney was not retained by the PIP insurer and the insurer did not intervene in the insured's suit against the tortfeasor.<sup>384</sup> One month later, in *Potts v. Goss*,<sup>385</sup> the supreme court rejected an insurer's argument that the trial court lacked jurisdiction to award attorneys' fees against it because it was not a party to the insured's action against the tortfeasor. The court held that section 3113a(e) is unambiguous and "does not limit jurisdiction to make such determinations to actions where the insurer is a named party."<sup>386</sup> The court also rejected the insurer's other arguments, including a contention the trial court lacked jurisdiction to fix attorneys' fees after it

<sup>379</sup> In *Easom v. Farmers Ins. Co.*, 221 Kan. 415, 427, 560 P.2d 117, 126 (1977), and in *Russell v. Mackey*, 225 Kan. 588, 594, 592 P.2d 902, 906 (1979), the supreme court construed KAN. STAT. ANN. § 40-3113a to mean that any judgment or settlement with a tortfeasor by an insured is duplicative of PIP benefits paid by the insurer. Under these decisions, a structured settlement which altogether avoids "duplicative PIP benefits" is not possible.

<sup>380</sup> See *Nitchals v. Williams*, 225 Kan. 285, 287-89, 590 P.2d 582, 584-85 (1979).

<sup>381</sup> 228 Kan. 506, 618 P.2d 1171 (1980).

<sup>382</sup> 228 Kan. at 510, 618 P.2d at 1175.

<sup>383</sup> 8 Kan. App. 2d 401, 659 P.2d 249 (1983).

<sup>384</sup> *Id.* at 407, 659 P.2d at 254.

<sup>385</sup> 233 Kan. 116, 660 P.2d 555 (1983).

<sup>386</sup> *Id.* at 118, 660 P.2d at 558.



dismissed the insured's action against the tortfeasor upon settlement.<sup>387</sup> The court gave notice that it would not countenance efforts of insurers to circumvent section 3113a(e): it described the insurer's appeal as "a legally baseless effort to avoid payment of its statutorily mandated fair share of the cost of recovery," found the appeal "frivolous in its entirety," and charged the insurer with attorneys' fees and costs.<sup>388</sup>

### 5. The KAIRA's Limitation on Tort Suits

Under the KAIRA, a person injured in an automobile accident has no right to sue in tort for nonpecuniary loss unless that person has suffered an injury of a serious nature described in the statute, or an injury requiring medical treatment having a reasonable value of at least \$500.<sup>389</sup> One ambiguity in the statute concerns the time by which the \$500 threshold must be met in order for a plaintiff to bring an action in tort for nonpecuniary loss. The supreme court clarified this matter in *Cansler v. Harrington*.<sup>390</sup>

The supreme court, in affirming the trial court, held that the plaintiff must accrue medical expenses of \$500 or more by the date of trial to meet the threshold. In *Key v. Clegg*,<sup>391</sup> the court of appeals had stated in a dictum that the threshold "must be met not later than the date of trial or the date the cause of action is barred by the statute of limitations, whichever first occurs."<sup>392</sup> The supreme court spoke approvingly of *Key*, but the court's holding in *Cansler* appears to make a significant modification of the *Key* rule.

The supreme court approved the trial court's understanding of *Key*: if a case is filed within the limitations period, the statute of limitations component of the *Key* rule becomes irrelevant, and the \$500 threshold need only be met before the date of the trial.<sup>393</sup> To illustrate the operation of this rule, assume that (1) plaintiff is injured in an accident on May 31, 1974; (2) plaintiff thereafter timely files a suit in tort for nonpecuniary damages; (3) at the time the complaint is filed the plaintiff has less than \$500 in medical expenses; (4) the plaintiff does not accumulate \$500 in medical expenses until three years after the suit is filed, which is one year after the statute of limitations would have run. Under *Cansler*, plaintiff's action cannot be dismissed, since plaintiff has met the \$500 threshold prior to trial. Under the *Key* rule, however, plaintiff's action would be dismissed, since the \$500 minimum was not reached until after the statute of limitations would have run.<sup>394</sup>

<sup>387</sup> *Id.* at 118-19, 660 P.2d at 558-59. The insurer, Farm Bureau Mutual Insurance Company, Inc., also argued that its insured's failure to obtain service on the son of the defendant in the insured's action prevented the insured from entering into a settlement with the defendant's insurer. The court described this argument as "even more implausible." *Id.* at 119, 660 P.2d at 558. The court also rejected Farm Bureau's objection to the size of the fee awarded the insured's attorney. *Id.* at 120, 660 P.2d at 559.

<sup>388</sup> *Id.* at 120-21, 660 P.2d at 559.

<sup>389</sup> KAN. STAT. ANN. § 40-3117 (1981).

<sup>390</sup> 231 Kan. 66, 643 P.2d 110 (1982).

<sup>391</sup> 4 Kan. App. 2d 267, 604 P.2d 1212 (1980).

<sup>392</sup> *Id.* at 273, 604 P.2d at 1217.

<sup>393</sup> 231 Kan. at 67, 643 P.2d at 112. This analysis draws some support from the well-settled rule that the timely filing of a complaint suspends the running of the statute of limitations.

<sup>394</sup> The supreme court seemed to interpret *Key* as really having one test—the date of trial. *Id.* at 67-68, 643 P.2d at 112. However, it appears that the court of appeals, in stating the "statute of limitations test," was referring to the date that the statute *would run* if it were not suspended by the timely filing of a complaint. Otherwise, the court of appeals had no reason to refer to the statute of limitations at all.

Arguably, the *Cansler* rule will encourage persons who suffer minor injuries to file actions in tort in the hope that by the time of trial \$500 of medical expenses will be incurred, thereby permitting the case to go to a jury and giving the plaintiff a chance to recover nonpecuniary losses. On the other hand, one might argue that since the defendant under both the *Key* and *Cansler* rules has an incentive to encourage an early trial so as to cut off the accumulation of medical expenses, it is not unfair if the plaintiff has an incentive to delay the trial in order to accumulate medical expenses. It is doubtful whether any of these "incentives" is very significant. Nevertheless, the policy of the KAIRA is to limit tort actions for nonpecuniary losses where the physical injury is relatively slight. Given this policy, it is not easy to understand why the court interpreted chapter 40, section 3117 so as to provide an extra incentive, however slight it may be, to file tort actions for nonpecuniary losses. A person who waits three years to file his complaint in a tort suit has no actionable claim; it is not unreasonable to prevent a person who does not incur \$500 in medical expenses within two years after the accident from bringing an action in tort for nonpecuniary loss.

#### 6. *Mopeds*

The question of whether a "moped" or "minibike" is a motor vehicle was settled prior to the survey period. In 1977, the legislature defined "motor vehicle" as a self-propelled vehicle other than a motorized bicycle and defined "motorized bicycle" as, in effect, a two-wheeled device with a small motor.<sup>395</sup> Thus, "motorized bicycles" are not motor vehicles that are subject to the compulsory liability insurance provisions of the KAIRA.

*Kresyman v. State Farm Mutual Automobile Insurance Co.*,<sup>396</sup> decided in 1981 by the court of appeals, held that motor vehicle liability insurance is required for any "mini-bike" operated on the public highways.<sup>397</sup> However, the accident that gave rise to that case occurred in 1975, when "motorized bicycles" were not excepted from the definition of motor vehicle. The court of appeals did not state explicitly that the case was being decided under statutory provisions no longer in force. Without this important bit of information, a casual reader of *Kresyman* seeking to acquire expertise in "moped law" could be seriously misled.

### B. *The Uninsured Motorist Statute*

#### 1. *Legislative Developments*

The other significant statute pertaining to automobiles and insurance is chapter 40, section 284 of the Kansas Statutes, the uninsured motorist statute. In 1982, this statute was also amended in a number of respects by Senate Bill 371.

First, section 284 was amended to provide that each automobile liability insurance policy must provide coverage limits for damages caused by uninsured motorists equal to the limits of liability coverage for the named insured. The

<sup>395</sup> Act of May 10, 1977, ch. 28, 1977 Kan. Sess. Laws 190 (amending KAN. STAT. ANN. § 8-126 and KAN. STAT. ANN. §§ 8-143, 8-235, 8-1439a, and 40-3103 (1976 Supp.)). Specifically, "motorized bicycle" was defined as a two-wheeled device with a motor with slight brake horsepower, limited cylinder capacity, an automatic transmission, and low "minimum design speed."

<sup>396</sup> 5 Kan. App. 2d 666, 623 P.2d 524 (1981).

<sup>397</sup> *Id.* at 669, 623 P.2d at 526.

insured is free to reject the coverage but only to the extent it exceeds the minimum limits of liability insurance required by section 3107.<sup>398</sup>

Since many insureds will carry higher limits of uninsured motorist coverage, the situation where the tortfeasor has purchased less liability coverage than the claimant has purchased for himself will occur more frequently. To clarify the result in such a situation, section 284 was also amended to provide that uninsured motorist coverage shall also include "underinsured" motorist coverage. Motorists who cause injury and have less liability coverage than the claimant himself possesses are labeled "underinsured." The claimant can recover his damages in excess of the limits of the tortfeasor's insurance from his own insurer up to his own policy limits.<sup>399</sup>

A third change in section 284 permits more expansive exclusions of coverage.<sup>400</sup> The insurer may exclude coverage when "[t]he insured is occupying an uninsured automobile owned or provided for the insured's regular use."<sup>401</sup> This statute was a response to earlier Kansas cases holding that uninsured motorist coverage protects the insured "wherever . . . he may happen to be."<sup>402</sup> For example, in *Merritt v. Farmers Insurance Co.*,<sup>403</sup> a court of appeals case decided under the prior law, the court held that the plaintiff, who was a passenger in an automobile she owned and had not insured, could recover as an "insured" under the driver's uninsured motorist coverage. Section 284 was amended to prevent such results, but even so the extent of the authorized exemption is not clear.

Plainly, it is no longer true that the uninsured motorist coverage mandated by the statute protects the insured "wherever he may happen to be." However, earlier Kansas cases invalidating exclusions for injuries arising as a result of occupying a vehicle (other than the insured vehicle) owned by the named insured do not seem to be affected by the amendments to section 284, since the amendments only authorize an exclusion for occupying an *uninsured* automobile owned by the insured or provided for the insured's use. Moreover, the statute uses the term "automobile," not "motor vehicle." "Automobile" is not defined, but a motorcycle is presumably not an automobile. Thus, the amendments to section 284 might not affect cases like *Barnett v. Crosby*,<sup>404</sup> where an uninsured motorist struck the plaintiff while plaintiff was riding an uninsured motorcycle he owned. The court held that plaintiff was not disqualified from recovering uninsured motorist benefits under a policy he had purchased for his automobile. While it might be

<sup>398</sup> KAN. STAT. ANN. § 40-284(a) (c) (1981).

<sup>399</sup> KAN. STAT. ANN. § 40-284(b) (1981).

<sup>400</sup> In addition to the authorized exclusions discussed in the text, the amendments to KAN. STAT. ANN. § 40-284 also authorized an insurer to exclude coverage when the "uninsured automobile is owned by a self-insurer or the federal government" KAN. STAT. ANN. § 40-284(e)(2)), "to the extent that workers' compensation benefits apply" (KAN. STAT. ANN. § 40-284(e)(4)), and when "suit is filed against the uninsured motorist without notice to the insurance carrier" (KAN. STAT. ANN. § 40-284(e)(5)).

<sup>401</sup> KAN. STAT. ANN. § 40-284(e)(1) (1981).

<sup>402</sup> *Midwest Mutual Ins. Co. v. Farmers Ins. Co.*, 3 Kan. App. 2d 630, Syl. ¶ 3, 599 P.2d 1021 (1979); *Forrester v. State Farm Mutual Automobile Ins. Co.*, 213 Kan. 442, 517 P.2d 173 (1973).

<sup>403</sup> 7 Kan. App. 2d 705, 647 P.2d 1355 (1982).

<sup>404</sup> 5 Kan. App. 2d 98, 612 P.2d 1250 (1980). In *Barnett*, plaintiff was injured when a car driven by an uninsured motorist struck the motorcycle plaintiff was riding. Plaintiff's motorcycle and family car were both insured, but only the policy carried on the car included uninsured motorist coverage. The court of appeals held invalid a clause in the automobile policy which "excluded injuries arising as a result of occupying a vehicle (other than the insured vehicle) which is owned by the named insured." The court held this exclusion void as "an attempt to dilute" the statutorily required uninsured motorist coverage which requires "protection of the insured wherever he may be." 5 Kan. App. 2d at 99, 612 P.2d at 1252.

argued that permitting such a plaintiff to recover uninsured motorist benefits under his separate automobile policy constitutes "stacking" which is now prohibited by section 284(d), a counter-argument is that the anti-stacking statute does not apply to a situation where the insured seeks to recover under *one* applicable policy. Perhaps a case will arise in the future clarifying this matter.

Section 284 also permits the insurer to exclude coverage when "there is no evidence of physical contact with the uninsured motor vehicle."<sup>405</sup> This reversed the effect of the supreme court's decision in *Simpson v. Farmers Insurance Company*,<sup>406</sup> in which the court invalidated as contrary to public policy and legislative intent a "physical contact" requirement in a hit-and-run clause in the uninsured motorist provision of an automobile policy.<sup>407</sup>

## 2. Vehicles Not Registered or Principally Garaged in Kansas

In *Wilds v. Mid-Century Insurance Co.*,<sup>408</sup> a Missouri resident who was injured in a collision with an uninsured motorist in Kansas City, Kansas, claimed that he was entitled to recover uninsured motorist benefits computed according to the lower minimums by Missouri law. The sole question decided by the supreme court was whether the KAIRA mandates the minimum levels of uninsured motorist coverage on policies owned by out-of-state motorists who have an accident in Kansas involving the nonresident's vehicle and an uninsured motorist.<sup>409</sup>

The court reasoned that the KAIRA "has no connection with uninsured motorist coverage except through K.S.A. 40-284," the specific statute on uninsured motorist benefits.<sup>410</sup> Section 284 applies "only when the motor vehicle is registered or principally garaged in this state."<sup>411</sup> Accordingly, a nonresident whose vehicles are neither registered nor principally garaged in Kansas and who collides in Kansas with an uninsured motorist is not entitled to recover uninsured motorist benefits in accordance with the minimums mandated by Kansas law.<sup>412</sup>

## C. A Summary of the Rules on Stacking

Stacking is a term which refers to obtaining for a single loss insurance proceeds from duplicate coverages. Courts throughout the country have considered in a variety of contexts whether stacking should be permitted, and the results in these cases vary widely.<sup>413</sup> During the survey period, legislative developments in Kansas altered much of the law of "stacking." The current status of the rules on stacking is summarized here.

### 1. Uninsured Motorist Benefits

Chapter 40, section 284, as amended in 1981, flatly prohibits stacking of unin-

<sup>405</sup> KAN. STAT. ANN. § 40-284(e)(3) (1981).

<sup>406</sup> 225 Kan. 508, 592 P.2d 445 (1979).

<sup>407</sup> *Id.* at 511, 592 P.2d at 448.

<sup>408</sup> 231 Kan. 124, 642 P.2d 567 (1982).

<sup>409</sup> After the accident which gave rise to this case, the minimums were raised to \$25,000. KAN. STAT. ANN. § 40-3107(e) (1981).

<sup>410</sup> 231 Kan. at 127, 642 P.2d at 569.

<sup>411</sup> *Id.* at 126-27, 642 P.2d at 569.

<sup>412</sup> *Id.* at 127, 642 P.2d at 569.

<sup>413</sup> See, e.g., Annot., 21 A.L.R.4th 211 (1983); Annot., 72 A.L.R.4th 108 (1983); Annot., 23 A.L.R.4th 12 (1983).

sured motorist benefits.<sup>414</sup> This is a reversal of prior case law, which had permitted uninsured motorist benefits to be stacked.<sup>415</sup>

## 2. *Liability Limits*

The 1981 legislature amended chapter 40, section 3107 to permit insurers to insert exclusions in liability policies that preclude stacking of liability limits.<sup>416</sup> Unlike the situation with uninsured motorist benefits, there is no rule that flatly prohibits stacking of liability limits.

## 3. *PIP Benefits*

It is now settled that the insurer may enforce a provision in a policy preventing the stacking of PIP benefits, with the possible exception of the situation where the insured has purchased two policies containing PIP endorsements on the vehicle which is involved in the accident.

Chapter 40, section 3108(a) of the Kansas Statutes permits an insurer to exclude benefits for injury sustained by the insured "while occupying another motor vehicle owned by the named insured and not insured under the policy." In *McNemee v. Farmers Insurance Group*,<sup>417</sup> the insured was injured while driving one of three vehicles he owned. A separate insurance policy covered each vehicle. Each policy contained identical PIP endorsements and a provision preventing the stacking of PIP coverages. The court held that the anti-stacking provisions were authorized by section 40-3108(a).

One year later, in *Davis v. Hughes*,<sup>418</sup> the supreme court considered a situation where the insured purchased one policy for two different vehicles and was injured while driving one of the vehicles. Also, a member of the insured's household owned a third policy on a third vehicle. The insured desired to stack the three PIP coverages, but the court rejected the insured's argument: "The intent of [K.S.A. 40-3108(a)] is to permit insurance carriers to insert provisions in policies preventing 'stacking' of PIP benefits—regardless of whether one or two policies are involved."<sup>419</sup>

This broad statement suggests that PIP benefits may not be stacked if the policy so provides. However, in *Bradley v. AID Insurance Co.*,<sup>420</sup> plaintiff was permitted to stack PIP benefits where he owned two policies on the same vehicle. Section 3108(a) did not apply, since the vehicle the insured occupied at the time of the accident was insured. The insurer argued that section 3109(b), which provides that if two or more insurers are liable to pay PIP benefits for the same injury to one person "the maximum benefits payable shall be the total of the various maximum benefits provided by this act and each insurer shall contribute a pro-rata share of the benefits," constitutes a legislative prohibition on stacking. The court rejected this argument, reasoning that the statute's purpose is "to prevent *double recovery* of benefits for the same items of loss, not to deny recovery of

<sup>414</sup> KAN. STAT. ANN. § 40-284(d) (1981).

<sup>415</sup> *E.g.*, *Davis v. Hughes*, 229 Kan. 91, 98, 622 P.2d 641, 648 (1981).

<sup>416</sup> KAN. STAT. ANN. § 40-3107(i)(6) (1981).

<sup>417</sup> 228 Kan. 211, 612 P.2d 645 (1980).

<sup>418</sup> 229 Kan. 91, 622 P.2d 641 (1981).

<sup>419</sup> *Id.* at 100, 622 P.2d at 649.

<sup>420</sup> 6 Kan. App. 2d 367, 629 P.2d 720 (1981).

actual damages above the specified limit of one policy when two policies for which premiums have been paid provide coverage.”<sup>421</sup> The court found support for its reasoning in chapter 40, section 3120, which provides that nothing in KAIRA “shall be construed as prohibiting or discouraging . . . the availability of motor vehicle liability insurance policies containing coverage exceeding that required to comply with [chapter 40, section 3118].”<sup>422</sup>

It appears that the result in *Bradley* approving stacking where the insured has purchased excess coverage on one vehicle does not depend on the fact that the two policies in question did not contain an anti-stacking provision. Rather, the court intimated that even if the policies contained a provision prohibiting stacking, such a provision would be void: “Allowing the defendants to limit recovery under these circumstances to the amount that could be recovered under one policy results in a windfall to the insurance companies. . . . We do not believe the legislature intended such a result.”<sup>423</sup> Accordingly, the court of appeals held that the trial court did not err in determining that the policies could be stacked: “To permit excess coverage for a higher premium from the same company, yet prohibit the purchase of two separate policies on the same vehicle to obtain such ‘excess’ coverage, would result in prohibiting or discouraging reasonable competition contrary to K.S.A. 1980 Supp. 40-3120.”<sup>424</sup>

Under these cases and the relevant statutes, it appears that an insurer may prohibit the stacking of PIP benefits except when the insured purchases two or more policies containing a PIP endorsement on the vehicle in which he is injured. This rule is fair, since the insurer provides coverage for the potential risk of injury incurred while the insured occupies a particular vehicle; if the insured pays a double premium on the vehicle, the insured should receive double coverage. However, the legislature may have spurned this analysis, since stacking of uninsured motorist coverage is prohibited and insurers may exclude stacking of liability limits. Because *Bradley* did not consider the possible effects of the 1981 “anti-stacking” amendments, it is likely that an insurer will again argue in a future case that PIP benefits cannot be stacked. Regardless of how this issue is ultimately resolved, it is certain that an insured cannot stack PIP benefits in excess of his actual loss.<sup>425</sup>

## V. MISCELLANEOUS OBSERVATIONS

There were, of course, other insurance law cases decided in Kansas during the survey period.

In *Price v. Trinity Universal Insurance Co.*,<sup>426</sup> the court of appeals reiterated that the existence of an insurable interest is a prerequisite to the validity of an insurance contract. The Court also reaffirmed that an insurable interest exists when the insured derives a pecuniary advantage by the preservation or continued exist-

<sup>421</sup> *Id.* at 385, 629 P.2d at 733.

<sup>422</sup> KAN. STAT. ANN. § 40-3118 (1981) requires, among other things, that no motor vehicle shall be registered in this state unless covered by a policy of liability insurance “as provided in this act.” As provided in the act, liability insurance must contain an endorsement for PIP benefits. KAN. STAT. ANN. § 40-3107(f) (1981).

<sup>423</sup> 6 Kan. App. 2d at 383, 629 P.2d at 732.

<sup>424</sup> *Id.* at 385, 629 P.2d at 733.

<sup>425</sup> *Id.* at 385-86, 629 P.2d at 733.

<sup>426</sup> 8 Kan. App. 2d 223, 654 P.2d 485 (1982).

ence of property or will sustain pecuniary loss from its destruction, and that rights arising out of a void or unenforceable contract do not give rise to an insurable interest.<sup>427</sup>

In *Branner v. Crooks*,<sup>428</sup> the court of appeals held that an appraisal form signed by the owner of a body shop where the body shop promised to make repairs to the insured's car for a guaranteed price *if* the insured chose to retain the body shop to make the repairs, was not a contract between the insurer and the body shop. That this claim was litigated is surprising; that the owner of the body shop actually prevailed in the trial court is remarkable.

The "omnibus clause," which is a provision of an insurance policy designating additional insureds through a description of a class of persons having some relationship to the named insured, continues to be a "source of dispute and litigation."<sup>429</sup> In *Cimarron Insurance Co. v. Loftus*,<sup>430</sup> the court of appeals reiterated the Kansas rule that "slight deviation from the purpose and use for which permission was granted does not preclude coverage under the omnibus clause."<sup>431</sup>

The disarray of the nation's health care industry has been evident for many years. Anyone still fortunate enough to be able to afford health insurance need only chart the increase in premiums to realize that a serious problem exists. This problem is receiving substantial attention from state government officials, in part because of growing public disenchantment with the status quo. Some aspects of the problem have found their way to the courts. Four times during the survey period Blue Cross of Kansas, Inc. appeared before the supreme court<sup>432</sup> "in litigation arising from conflicting ideas of how best to contain spiraling hospital service costs in Kansas."<sup>433</sup> In none of the four cases was an important principle of insurance law developed, but the cases are important at least because they remind us that a major problem with vital public policy implications has not disappeared.

In 1980, Kansas became one of a few focal points in an ongoing conflict between state and federal regulatory efforts. The insurance industry is the largest business in this country which has successfully avoided significant federal regulation. This is due in part to Congress' declaration of policy in the McCarran-Ferguson Act that the business of insurance should be regulated by the states.<sup>434</sup> Kansas and most other states have adopted insurance holding company legislation, patterned after model legislation drafted by the National Association of Insurance Commissioners.<sup>435</sup> These statutes require the prior approval of the state insurance commissioner before control of a domestic insurer can be transferred to another party. Similar legislation requiring the prior approval of state officials before a domestic corporation can be acquired has also been enacted in most

<sup>427</sup> *Id.* at 224, 654 P.2d at 486-87.

<sup>428</sup> 6 Kan. App. 2d 813, 635 P.2d 1265 (1981).

<sup>429</sup> Oldfather, *supra* note 4, at 266. See generally Annot., 21 A.L.R.4th 1146 (1983).

<sup>430</sup> 5 Kan. App. 2d 90, 612 P.2d 1245 (1980).

<sup>431</sup> *Id.* at 93, 612 P.2d at 1247.

<sup>432</sup> *Augusta Medical Complex v. Blue Cross of Kansas*, 230 Kan. 361, 634 P.2d 1123 (1981); *Comanche County Hosp. v. Blue Cross of Kansas*, 228 Kan. 364, 613 P.2d 950 (1980); *Augusta Medical Complex v. Blue Cross of Kansas*, 227 Kan. 469, 608 P.2d 890 (1980); *Blue Cross & Blue Shield of Kansas v. Bell*, 227 Kan. 426, 607 P.2d 498 (1980).

<sup>433</sup> 230 Kan. at 361, 634 P.2d at 1124.

<sup>434</sup> 15 U.S.C. § 1012 (1982).

<sup>435</sup> *E.g.*, KAN. STAT. ANN. §§ 40-3301 to -04 (1981).

states; many of these statutes have been declared unconstitutional on supremacy and commerce clause grounds.<sup>436</sup>

In *Professional Investors Life Insurance Co. v. Roussel*,<sup>437</sup> the Kansas insurance holding company act was alleged to be unconstitutional for the same reason. In a dictum, the federal district court rejected this argument, opining that the Kansas statute was intended to protect policyholders, not security holders, and therefore the McCarran-Ferguson Act protected it from preemption by the Williams Act because the Kansas statute regulates the "business of insurance" left to state regulation by Congress.<sup>438</sup> The final word on this issue is not yet in. Wisely, in 1983, the Kansas legislature deleted a provision of the Kansas statute stating that the insurance commissioner can disapprove a proposed acquisition of a domestic insurer if he concludes that the acquisition would adversely affect the interests of the insurer's shareholders.<sup>439</sup> The deletion of this provision will aid those who will one day defend the statute against a constitutional assault.

Finally, one of the biggest developments affecting insurance law in Kansas and every other state looms on the horizon. Currently, both houses of Congress are considering legislation that would prohibit the use of sex-based tables to compute premiums and payments in all kinds of insurance.<sup>440</sup> The Supreme Court has held that employers may not base either contributions to or payments from employer-provided annuities on sex.<sup>441</sup> The 1984 session of the Kansas legislature may consider state legislation to limit the use of sex-based tables in insurance.<sup>442</sup>

The smaller world of insurance reflects both the complexities and purposes of the larger world outside it. That "rule" did not change during this survey period. Indeed, it is the one rule that will never change.

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<sup>436</sup> See *Edgar v. Mite Corp.*, 457 U.S. 624 (1982).

<sup>437</sup> 528 F. Supp. 391 (D. Kan. 1981).

<sup>438</sup> *Id.* at 402.

<sup>439</sup> Act of April 15, 1983, ch. 159, 1983 Kan. Sess. Laws 859, 862-63.

<sup>440</sup> H.R. 1000; S. 372, 98th Cong., 1st Session (1983).

<sup>441</sup> *Arizona Governing Committee v. Norris*, 103 S. Ct. 3492 (1983) (payments); *Los Angeles Dep't of Water & Power v. Manhart*, 435 U.S. 702 (1978) (contributions).

<sup>442</sup> *Insurance Chief Says High Court Ruling Should Not Affect Existing Pension Plans*, The Lawrence Daily Journal World, July 7, 1983, at 1, col. 3, at 3, col. 6 (quoting Kansas Insurance Commissioner Fletcher Bell predicting that such legislation will be introduced in 1984 session).



