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The Devil Is in the Details: Establishing an Insured's Intent to Deceive in Life and Health Insurance Rescission Cases†

Gary Schuman

I. Introduction

Life, health and disability insurance companies, especially those selling coverage to individuals and small groups, are not required to issue coverage to any applicant for insurance. Rather, they are permitted to select the risks they will insure and to deny or limit coverage through a process known as "underwriting."[1]

Underwriting ensures that each applicant receives fair and consistent evaluation and, if accepted, is charged an appropriate premium for the coverage offered. One of the basic principles of insurance is that each individual accepted for coverage should pay a premium that is proportionate to the amount of risk the company assumes for that person.[2] Otherwise many people seeking to purchase insurance in the individual and small group markets would pay considerably higher premiums.

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† Submitted by the author on behalf of the FDCC Life, Health and Disability Section.

[1] Quelimane Co. v. Stewart Title Guar. Co., 77 Cal. Rptr. 2d 709, 719 (1998); Farm Bureau Life Ins. Co. v. Holmes Murphy & Assocs., Inc., No. 831 N.W.2d 129, 135 (Iowa 2013).

[2] *See* Bryan Bros., Inc. v. Continental Cas. Co., 660 F.3d 827, 831 (4th Cir. 2011); *see also* Chicago Ins. Co. v. Capwill, No. 1:01CV2588, 2011 WL 6440756, at *4 (N.D. Ohio Dec. 21, 2011). A fundamental principle of insurance is "fortuity." Insurers do not agree to insure preexisting risks the insured knew about.

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With some variations depending on the type of insurance coverage sought, insurers primarily base underwriting decisions on an applicant's responses to questions regarding the applicant's medical history, employment record, social activities and earnings history.[3] The prospective insured has a duty to provide truthful and complete answers to the questions posed so the insurer can properly evaluate the risk it is contracting to insure.[4] This is so because the insurer is in an unequal position vis-à-vis the applicant when it comes to obtaining the needed information to properly assess the applicant's health and other risk factors.[5]

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[3] *See* Colony Ins. Co. v. Abercorn, LLC, 866 F. Supp. 2d 1376, 1379 (S.D. Ga. 2012); *Capwill*, 2011 WL 6440756, at *4; Mass. Mut. Life Ins. Co. v. Zaucha, No. 10 C 1978, 2011 WL 3584766, at *2 (N.D. Ill Aug. 15, 2011).

[4] *See* Am. Gen. Life Ins. Co. v. Garcia, No. 07-3179 (RMB/KMW), 2009 WL 2905372, at *4 (D.N.J. Sept. 10, 2009); *Capwill*, 2011 WL 6440756, at *4. The insured has a duty to deal fairly with the insurer. This includes the duty not to conceal or misrepresent material information requested on the application. Rashabov v. Alfuso, No. A-3684-08T1, 2010 WL 3932899, at *3 (N.J. Super. Ct. App. Div. Sept. 28, 2010).

[5] *See* Allianz Life Ins. Co. of Am. v. Estate of Bleich, No. 08-668 (SDW) (MCA), 2012 WL 714686, at *11-12 (D.N.J. Mar. 5, 2012).

People with certain health conditions or who engage in dangerous occupations or social activities may be required to pay higher premiums, may be subject to policy exclusions or, in cases of excessive risk, may be denied coverage altogether. As a consequence, some individuals may fail to disclose adverse conditions or activities on the application so they may either obtain insurance not otherwise available or pay premiums lower than justified had they disclosed the true facts.[6]

The insurer often discovers false information on an application only after a claim is submitted.[7] The insurer may then seek to rescind the policy if it determines that had the applicant correctly disclosed all of the requested material facts it would have declined to issue coverage, would have limited the type of coverage issued or would have charged a higher premium.[8]

Many legal issues arise when an insured challenges the insurer's decision to rescind. Some of the most important of these include whether there actually was a "misrepresentation" based on the application questions presented; whether the misrepresentation was "material"; and, in those states that impose such a requirement, whether the misrepresentation was "intentional."

States requiring the insurer to present evidence of the insured's intent to deceive have adopted a variety of standards to determine "intent." As a result, insurers often have a difficult time determining whether this critical requirement has been satisfied. This Article first addresses how various states define what constitutes a "knowing" misrepresentation and under what circumstances an insured's failure to disclose requested information constitutes

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[6] An insurer is not able to fully investigate each applicant and discover less obvious health issues. *See* Golden v. Nw. Mut. Life Ins. Co., 551 A.2d 1009, 1014 (N.J. Super. Ct. App. Div. 1988). Insurers do not intend to cover a reasonably certain loss in the immediate future. *See* Nat'l Life Ins. Co. v. Harriott, 268 So. 2d 397, 400 (Fla. Dist. Ct. App. 1972).

[7] *See* Hailey v. Cal. Physicians' Serv., 69 Cal. Rptr. 3d 789, 799 (Ct. App. 2008); Hagan v. Cal. Physicians' Serv., No. A130809, 2011 WL 6820396, at *5-6 (Cal. Ct. App. Dec. 28, 2011). Policies often contain one or two year contestable time period provisions, allowing an insurer to investigate and, if appropriate, challenge the accuracy of the insured's application responses. In fact, some insurers will conduct "routine" eligibility investigations whenever a claim is filed within this time period. Salkin v. U.S. Auto. Ass'n, No. 835 F. Supp. 2d 825, 829 (C.D. Cal. 2011), *aff'd*, 544 F. App'x 713 (9th Cir. 2013). However, once the insured survives the stated contestable time period, then the insurer is prevented from rescinding coverage. Cardenas v. United of Omaha Life Ins. Co., 731 F.3d 496, 500 (5th Cir. 2013); *but see* Conseco Life Ins. Co. v. Heady, No. 2:11-cv-3716 (SDW) (MCA), 2013 WL 3285065, at *6 (D.N.J. June 26, 2013) (New Jersey permits rescission outside the contestable time period when the insurer can prove actual fraud).

[8] The Patient Protection and Affordable Care Act ("PPACA") was enacted on March 23, 2010 (Pub. L. No. 111-148, 124 Stat. 119). PPACA prohibits insurers from rescinding medical insurance coverage in the absence of *fraud*. PPCA also calls for "Guarantee Issue," preventing insurers from rescinding on the basis of any misrepresentation involving the insured's health or medical history. This law will limit, but certainly not eliminate, an insurer's ability to rescind for a variety of insurance products such as health and accident, life, disability and supplemental coverage.

an intentional act of deception. It then suggests ways insurers can protect themselves from contract and bad faith challenges by the insured or beneficiary when coverage is rescinded.

II.
The Application Process

Insurers typically require an applicant to complete an application that, depending on the type of coverage sought, includes questions about the applicant's medical history (including physicians seen, prescriptions taken and other similar information); employment history; and social activities (such as the use of alcohol, tobacco products or recreational drugs).[9] In signing the application, the applicant generally attests to the accuracy and completeness of the information provided.[10]

A. *Application Questions*

Questions on the application should seek to obtain all the information the insurer needs to make an informed underwriting decision.[11] The insured has an affirmative duty to know and understand the content of the application and will be bound by the representations made in his or her answers.[12] However, an insured has no duty to volunteer information. Thus, an insured is obligated to disclose only that information specifically and unambiguously sought in the application.[13]

Application questions are either objective or subjective. In the context of rescission, this distinction is especially important in proving whether the application contains a misrepresentation and, in jurisdictions requiring intent, whether the misrepresentation was intentional.

1. Objective Questions

Objective questions provide the most protection to an insurer. Such questions are typically specific and easily understandable, and seek disclosure of information readily within the applicant's knowledge, such as the names of doctors or other medical professionals who have seen or treated the applicant; medications prescribed for the applicant, including

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[9] *See*, *e.g.*, *Hagan*, 2011 WL 6820396, at *3.

[10] *See*, *e.g.*, Adam v. Stonebridge Life Ins. Co., 612 F.3d 967, 972 (8th Cir. 2010).

[11] *See* Weeks v. Ohio Nat'l Life Assur. Corp., No. 1:10-cv-566-BLW, 2011 WL 5835596, at *4 (D. Idaho Nov. 21, 2011).

[12] *See* Rashabov v. Alfuso, No. A-3684-08T1, 2010 WL 3932899, at *4 (N.J. Super. Ct. App. Div. Sept. 28, 2010); *see also* La Plant v. Household Life Ins. Co., No. 12-C-684, 2013 WL 3341054, at *3 (E.D. Wis. July 2, 2013) (courts will view application questions as they would be understood by a layperson).

[13] *See* Barrera v. Am. Nat'l Prop. & Cas. Co., No. 12-cv-00413-WYD-MEH, 2013 WL 5426349, at *8 (D. Colo. Sept. 27, 2013); *see also* Sheinbaum v. Am. Cas. Co. of Reading, Pa., No. 09-273 (CKK), 2010 WL 3909209, at *6 (D.D.C. Oct. 1, 2010) (the term "registered nurse" is not limited to persons registered in the United States).

narcotics or other controlled substances; the applicant's alcohol, tobacco or recreational drug use; or any specific medical conditions considered important by the insurer.[14] Objective inquiries may also include questions regarding an applicant's income and net worth, previous purchase or cancellation of insurance coverage, previous suspension or revocation of a driver's license, and conviction of a misdemeanor or felony.[15]

An insured may also be required to disclose information in response to questions that are not so specific. For example, in response to a question asking whether the insured has "any disease of the nervous system," the insured must disclose a history of epilepsy.[16] So, too, a question inquiring generally about "any other disease or injury" requires the disclosure of vascular hypertension.[17] And a question seeking information about the applicant's "last physician visit" requires the disclosure of the applicant's visit to a gynecologist, even though this medical specialty is not listed on the application.[18]

These types of questions are considered to be objective because their accuracy may be proven by direct evidence, giving rise to a presumption that the matter is material to the insurer's ability to properly underwrite the risk.[19] The applicant's personal belief regarding the seriousness of a health condition is irrelevant.[20] The insurer, not the applicant, determines what issues are important in deciding whether the applicant is an acceptable risk and, if so, on what terms.[21]

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[14] *See*, *e.g.*, Nichols v. Nw. Mut. Life Ins. Co., 487 F. App'x 339, 341 (9th Cir. 2012) (chiropractic care); Siudut v. Banner Life Ins. Co., No. 12 C 1726, 2013 WL 4659563, at *3 (N.D. Ill. Aug. 30, 2013) (alcohol abuse); Mitchell v. Banner Life Ins. Co., No. 08-5984 (JLL), 2011 WL 5878378, at *6-7 (D.N.J. Nov. 22, 2011); Mass. Mut. Life Ins. Co. v. Jordan, No. 3:10-0016, 2011 WL 1770435, at *4 (S.D. W. Va. May 9, 2011) (controlled substances (heroin)).

[15] *See*, *e.g.*, Principal Life Ins. Co. v. Locker Grp., 869 F. Supp. 2d 359, 365 (E.D.N.Y. 2012) (financial information); PHL Variable Ins. Co. v. Sheldon Hathaway Family Ins. Trust, No. 2:10-cv-67, 2013 WL 6230351, at *1 (D. Utah, Dec. 2, 2013) (financial information); Johnson v. Household Life Ins. Co., No. 5:11-CV-301-BR, 2012 WL 5336959, at *2 (E.D.N.C. Oct. 26, 2012) (driver's license revocation). However, courts have concluded that some common terms are ambiguous when undefined. *See*, *e.g.*, Mega Life & Health Ins. Co. v. Pieniozek, 585 F.3d 1399, 1406 (11th Cir. 2009) (meaning of "annual income" is ambiguous); *see also* Hutchinson v. Liberty Life Ins. Co., 743 S.E.2d 827, 829 (S.C. 2013) (meaning of "narcotic" is ambiguous).

[16] Hagan v. Cal. Physicians' Serv., No. A130809, 2011 WL 6820396, at *14 (Cal. Ct. App. Dec. 28, 2011) (citing Freeman v. Allstate Life Ins. Co., 253 F.3d 533, 536-37 (9th Cir. 2001)).

[17] *Id.* (citing Robinson v. Occidental Life Ins. Co. of Cal., 281 P.2d 39, 41 (Cal. Dist. Ct. App. 1955)).

[18] *Hagan*, 2011 WL 6820396, at *3.

[19] *Id.* at *11. *See also* Tudor Ins. Co. v. Hellickson Real Estate, 810 F. Supp. 2d 1211, 1217 (W.D. Wash. 2011).

[20] *See* Salkin v. USAA Life Ins. Co., 544 F. App'x 713, 714 (9th Cir. 2013).

[21] *See* Chicago Ins. Co. v. Capwill, No. 1:01CV2588, 2011 WL 6440756, at *4 (N.D. Ohio Dec. 21, 2011).

2. Subjective Questions

Insurance applications may also include questions that are considerably more subjective. These questions are subject to interpretation and seek the applicant's subjective belief or judgment as to the state of the applicant's health[22]—e.g., questions asking whether the applicant is "in good health" or "free from any physical or mental disorder."[23] Because such subjective questions inquire into the applicant's state of mind, they are inherently more ambiguous.[24]

Courts are more lenient when reviewing responses to subjective questions for possible misrepresentations. Courts have interpreted such questions to mean that the insurer is interested only in "serious" medical conditions as understood from the point of view of a layman, not from that of a medical professional.[25] The failure to mention minor or temporary indispositions is not considered to be material to the risk.[26] Thus, application questions inquiring about an individual's overall heath will not hold an applicant to the literal truth. Such questions—e.g., is the applicant "free from disease?"—require only that the applicant has a good faith belief, or is justified in believing, that his or her response is truthful.[27] For such a representation to be actionable, the insurer must demonstrate not only that the answer is false, but also that the insured *knew it was false*.[28] So long as the response is true in the broader sense that it is honest, sincere and not fraudulent, there is no misrepresentation.[29]

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[22] Williams v. Union Fidelity Life Ins. Co., 123 P.3d 213, 222 (Mont. 2005).

[23] *Id.* at 216; Brondon v. Prudential Ins. Co. of Am., No. 09-CV-6166T, 2010 WL 4486333, at *8 (W.D.N.Y. Nov. 9, 2010) ("good health"). So, too, "disease or disorder" is considered to be subjective and the insured must prove the insured actually knew he had the specific medical condition. Barry v. U.S. Life Ins. Co., No, 2:09-cv-1790 (DMC) (JAD), 2011 WL 1832995, at *3 (D.N.J. May 12, 2011); Wetherspoon v. Columbus Life Ins. Co., No. 11-CV-3230, 2013 WL 241238, at *4 (N.D. Ill. Jan. 18, 2013) ("disorder").

[24] *See* Allianz Life Ins. Co. of Am. v. Estate of Bleich, No. 08-668 (SDW)(MCA), 2012 WL 714686, at *8 (D.N.J. Mar. 5, 2012); *see also* Mitchell v. Banner Life Ins. Co., No. 08-5984 (JLL), 2011 WL 5878378, at *5 (D.N.J. Nov. 22, 2011). An ambiguous question is one that is susceptible to two reasonable interpretations so that either an affirmative or negative response by an objectively reasonably person would be correct. *See also* Ocean's Bar & Grill, Inc. v. Indem. Ins. Corp., No. 11-61577-CIV, 2012 WL 5398625, at *13 (S.D. Fla. Nov. 2, 2012).

[25] *See* United Nat'l Ins. Co. v. Granoff, Walker & Forlenza, 598 F. Supp. 2d 540, 547 (S.D.N.Y. 2009); *see also* Fireman's Fund Ins. Co. v. DeNiro, No. B208336, 2009 WL 1652971, at *10 (Cal. Ct. App. June 15, 2009); West Coast Ins. Co. v. Hoar, 558 F.3d 1151, 1157 (10th Cir. 2009) ("in the context of answering an insurance application question which calls for a value judgment, '[a] particular misrepresentation . . . must be such that a [r]easonable person would, under the circumstances, have understood that the question calls for disclosure of specific information'") (citation omitted; alteration in original).

[26] Courts have interpreted subjective questions to mean that the insured must disclose only "serious" medical conditions as understood from the standpoint of the ordinary person. *DeNiro*, 2009 WL 1652971, at *10.

[27] *See Williams*, 123 P.3d at 222; *see also Mitchell*, 2011 WL 5878378, at *5.

[28] Consumer First Ins. Co. v. Lee, No. L-13386-04, 2009 WL 425948, at *4 (N.J. Super. Ct. App. Div. Feb. 24, 2005).

[29] *Barry*, 2011 WL 1832995, at *3; *Mitchell*, 2011 WL 5878378, at *5-6.

For example, in *Wetherspoon v. Columbus Life Insurance Co.*,[30] the insured applied for, and was issued, a life insurance policy. In response to questions on the application, the insured stated she had not previously consulted a medical practitioner for a disorder of the stomach, that she was not under any treatment or observation and that she was not taking any medication.[31] Just prior to signing the application, however, the insured had been evaluated twice at a hospital emergency room for abdominal pain, was prescribed medication for acid reflux and underwent a CT scan.[32] Soon after the insured completed the application, the radiologist read the CT scan and found a potentially cancerous stomach mass, which ultimately was confirmed as cancer.[33] Three months later, the insured died. The insurer rescinded coverage.

The court denied summary judgment to the insurer.[34] First, there was a triable issue whether the insured had a stomach disorder within the meaning of the application. According to the court, being treated twice for indigestion and abdominal pain and being prescribed medication for acid reflux may not constitute a "disorder."[35] The application did not define "disorder," so its meaning in the application was not known. Objectively, the insured could have reasonably believed her condition did not constitute a stomach disorder.

Likewise, the insured's statement that she was not under treatment or observation was not actionable. A layperson's understanding of "treatment or observation" may differ from that of a medical professional.[36]

Finally, although the insured had been *prescribed* medication, her daughter testified the insured *never took* the medication. Thus, there was a disputed issue whether the insured was "taking medication" when she completed the application.[37]

Similarly, in *Barry v. United States Life*,[38] John Barry applied for a life insurance policy on December 26, 2006.[39] He completed an application representing that he had no "disease or disorder" of his liver, but stated he was being treated for hypertension. The policy was issued on January 15, 2007, and he died one month later.

During its investigation, the insurer learned that Barry's doctor advised him to have an ultrasound based on an abnormal blood test regarding his liver function. U.S. Life argued that Barry's failure to reveal this information justified rescinding coverage. Barry sued, and the insurer sought summary judgment, which the district court denied.

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[30] No. 11-CV-3230, 2013 WL 241238 (N.D. Ill. Jan. 18, 2013).

[31] *Id.* at *2.

[32] *Id.* at *1.

[33] *Id.*

[34] *Id.* at *5.

[35] *Id.* at *4.

[36] *Id.*

[37] *Id.*

[38] No. 2:09-cv-1790 (DMC) (JAD), 2011 WL 1832995 (D.N.J. May 12, 2011).

[39] *Id.* at *1

The "one crucial and material fact" before the court was whether Barry actually knew the state of his health in December 2006 and what he thought the application was asking regarding his health.[40] Barry argued, and the court agreed, that the question regarding liver disease or disorder was a subjective question and would thus be considered false only if Barry actually knew he had a liver "disease" or "disorder."[41]

Although there was no question that. Barry was "a gravely ill man,"[42] it was not clear that he knew he was sick. The recommended test was presumably to assist the doctor in making that determination.[43] The fact that Barry did not have the ultrasound test ordered by his doctor eight months earlier actually supported his contention he did not believe he had any disease or disorder. Nor was there anything to show Barry's abnormal blood test results were conveyed to him in such a manner as to indicate he knew or understood the seriousness of these results.[44]

B. *Insurer's Duty to Investigate*

A very important element of the insurer's underwriting evaluation is trust.[45] An insurer is entitled to receive honest and complete answers from applicants for insurance.[46] An applicant who is aware of any medical condition, symptom or treatment thus has a duty to disclose this information if asked.[47]

The law permits insurers to rely on the information contained in an insured's application.[48] When the insured's answers are complete on their face, the insurer has no independent obligation to investigate their accuracy.[49] This rule is premised on the fact that only the applicant has the requisite knowledge of his or her health and other issues.[50] An insurer has a

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[40] *Id.* at *2.

[41] *Id.* at *1, 3.

[42] *Id.*

[43] *Id.* at *3.

[44] *Id.*

[45] Both parties to an insurance contract owe each other a duty of good faith and fair dealing. *See* Lunardi v. Great-West Life Assur. Co., 44 Cal. Rptr. 2d 56, 66 (Ct. App. 1995); *see also* Goff v. Penn Mut. Life Ins. Co., 729 S.E.2d 890, 892 (W. Va. 2012).

[46] *See*, *e.g.*, Portillo v. Nationwide Mut. Fire Ins. Co., 671 S.E.2d 153, 155 (Va. 2009).

[47] Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898, 904 (8th Cir. 2003).

[48] Pierce v. United Home Life Ins. Co., 914 F. Supp. 2d 826, 831 (S.D. Miss. 2012); Mass. Mut. Life Ins. Co. v. Zaucha, No. 10 C 1978, 2011 WL 3584766, at *6 (N.D. Ill. Aug. 15, 2011).

[49] *See* State Farm Mut. Auto. Ins. Co. v. Cockram, No. 2:11-cv-161-FtM-29DNF, 2012 WL 3155620, at *2 (M.D. Fla. Aug. 3, 2012); Love v. Liberty Ins. Corp., No. 11-10740, 2011 WL 5143383, at *2 (E.D. Mich. Oct. 31, 2011); Mass. Mut. Life Ins. Co. v. Jordan, No. 3:10-0016, 2011 WL 1770435, at *5 (S.D. W. Va. May 9, 2011).

[50] *See* Allianz Life Ins. Co. of America v. Estate of Bleich, No. 08-668 (SDW)(MCA), 2012 WL 714686, at *8 (D.N.J. Mar. 5, 2012).

duty to investigate representations on an application only if there is information that would put a reasonably prudent insurer on notice of a possible misrepresentation.[51]

Relying on these legal principles, insurers may utilize simplified underwriting procedures to approve or reject applications for coverage. Courts have upheld the use of these types of applications against challenges that a more through investigation prior to coverage would have disclosed the insured's medical problems.

For example, in *Adam v. Stonebridge Life Insurance Co.*, the insured applied for a $75,000 term life insurance policy, listing his occupation as "Laborer—Part time Social Security."[52] The application asked a number of specific questions, including whether the applicant had ever received treatment or medical advice or been hospitalized for any nervous or mental disorder within the past five years. He replied "no."[53] In fact, the insured had been diagnosed with bipolar disorder and was receiving treatment from a psychiatrist.

The application responses were reviewed by computer. Under the insurer's system, any affirmative response to a health question resulted in automatic rejection of the application. Conversely, if all health questions were answered "no," the insurance would immediately be approved. Should a misrepresentation be discovered later, the policy would be rescinded.[54] Because the insured answered "no" to all questions, the insurer issued coverage without undertaking any investigation to determine why a 45 year old person was receiving Social Security benefits.[55]

Less than four months later, the insured was killed in an automobile accident.[56] The subsequent investigation uncovered the insured's misrepresentations, and coverage was rescinded.

The beneficiary sued, alleging in part that the insurer did not reasonably rely on the insured's representations because the insured's disclosure that he was receiving Social Security benefits triggered an obligation to investigate further before issuing coverage.[57] According to the insurer, however, it justifiably relied on the insured's representations because its simplified underwriting process was commonly used in the industry and it had no reason to doubt the insured's negative responses to the health questions. The court agreed, noting that the application specifically stated the insurer would rely on the applicant's responses in issuing coverage.[58] The fact that the insured referred to receiving Social Security benefits

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[51] Harper v. Fid. & Guar. Life Ins. Co., 234 P.3d 1121, 1218 (Wyo. 2010); Silver v. Colo. Cas. Ins. Co., 219 P.3d 324, 331-32 (Colo. App. 2009); *Allianz*, 2012 WL 714686, at *8.

[52] 612 F.3d 967, 969 (8th Cir. 2010).

[53] *Id*.

[54] *Id.*

[55] *Id.* at 970.

[56] *Id.*

[57] *Id.* at 973.

[58] *Id*.

did not change that result. An individual may be receiving Social Security benefits and still not have received medical treatment or advice within the previous five years. Thus, it was not obvious the insured was lying.[59]

Similarly, in *Harper v. Fidelity & Guaranty Life Insurance Co.*,[60] Joseph Harper purchased a life insurance policy. The application contained questions regarding the applicant's current and past health history.[61] Harper denied receiving medical treatment or advice for a number of medical conditions, acknowledging only that he was taking medication for high blood pressure and high cholesterol.

The insurance applied for was considered by the insurer to be a "simplified underwritten product" whereby the underwriter simply reviewed the application and obtained information from the Medical Information Bureau ("MIB").[62] Based on this investigation, the underwriter learned Harper's weight was slightly higher than represented but assumed Harper's weight had been lower on the date of the application.[63] Nor was the underwriter concerned that Harper had received treatment for depression treatment 10 years earlier, since Harper stated he had made a "complete recovery."[64] The underwriter also assumed Harper's blood pressure and cholesterol were most likely under control because he was taking medication for these conditions. Coverage was approved.[65]

Harper died two months later from cardiac problems. At that point, the insurer learned for the first time that Harper had failed to disclose treatment for a "probable transient and ischemic attack," alcohol abuse and liver problems, and chest pains. It also learned Harper's weight was significantly higher than stated on the application and MIB report. Accordingly, coverage was rescinded. The beneficiary sued, and the insurer obtained summary judgment.[66]

The beneficiary argued the insurer should have investigated further based on the application and MIB responses. The beneficiary contended there were "red flags" which the underwriter ignored.[67] The court rejected these arguments, noting that the underwriter adequately explained why no further investigation was undertaken: "In the simplified underwriting process that was used [here], the underwriter is to rely on the health questionnaire and the MIB, which is what happened in this instance. Furthermore, Mr. Harper represented in his

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[59] *Id.* at 973-74.

[60] 234 P.3d 1211 (Wyo. 2010).

[61] *Id.* at 1214.

[62] *Id.* at 1219.

[63] *Id*.

[64] *Id.* at 1215.

[65] *Id*.

[66] *Id*.

[67] *Id.* at 1219.

application that '[t]he statements made in this application are complete, true and correctly recorded.'"[68] An insurer is not obligated to further investigate unless it is placed on notice that the application responses are inaccurate.[69] That was not the case here, and rescission was therefore proper.

III.
Rescinding Coverage

A. *Insurer's Right to Rescind*

It is a basic principle of contract law that if one party to a contract has been led to enter into the agreement by the misrepresentation of the other party, the contract is voidable at the option of the innocent party.[70] Accordingly, rescission is available to an insurer when an insurance policy is obtained based on incorrect information communicated by the insured that was material to the formation of the contract.[71] In many states, in order for an insurer to rescind coverage, the application must clearly and unambiguously state that a misstatement by the insured will void the policy *ab initio*.[72]

The ordinary result of the rescission of a policy is that the contract is void *from the outset* (i.e., *ab initio*). The policy is treated as if it never existed, and the parties are restored to the position they were in before the contract was created.[73]

Rescission requires notice to the insured and a tender of all premiums paid.[74] In addition to giving direct notice to the insured, an insurer can satisfy the notice requirement by

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[68] *Id*.

[69] *Id.* at 1218.

[70] *See*, *e.g.*, New England Life Ins. Co. v. Signorello, 119 F. Supp. 2d 1052, 1059 (N.D. Cal. 2000).

[71] Pruco Life Ins. Co. v. Wilmington Trust Co., 721 F.3d 1, at *6 (1st Cir. 2013); S.B. v. United of Omaha Life Ins. Co., No. 13-1463, 2013 WL 2915973, at *4 (E.D. Pa. June 13, 2013).

[72] *See* Unencumbered Assets Trust v. Great Am. Ins. Co., 817 F. Supp. 2d 1014, 1026 (S.D. Ohio 2011).

[73] *See* Merritt v. Hub Int'l Sw. Agency, Ltd., No. 1-09–CV–00056–JEC, 2011 WL 4026651, at *6 (N.D. Ga. Sept. 12, 2011). Rescission and cancellation are not the same. *See* Indem. Ins. Corp. of DC, RRG v. AMPA Inc., No. 12-689 (JNE/JJG), 2012 WL 2045297, at *3 (D. Minn. June 6, 2012) (rescission is the termination of coverage from the outset; cancellation is the prospective termination of the contract); *see also* Nat'l Grange Mut. Ins. Co., Inc. v. Judson Constr., Inc., 931 F. Supp. 2d 373, 379 (D. Conn. 2013); Hagan v. Cal. Physicians' Serv., No. A130809, 2011 WL 6820396, at *11 (Cal. Ct. App. Dec. 28, 2011).

[74] *See* PHL Variable Ins. Co. v. Faye Keith Jolly Irrevocable Life Ins. Trust, 460 F. App'x 899, 902 (11th Cir. 2012); *but cf.* PHL Variable Ins. Co. v. Morello, 645 F.3d 965, 970 (8th Cir. 2011) (holding that in the STOLI context, where fraud is proven, there is no duty to refund premiums); *see also* PHL Variable Ins. Co. v. Sheldon Hathaway Family Ins. Trust, No. 2:10-cv-67, 2013 WL 6230351, at *9 (D. Utah Dec. 2, 2013); Dodd v. Am. Family Mut. Ins. Co., 956 N.E.2d 769, 774 (Ind. Ct. App. 2011), *rev'd on other grounds*, Dodd v. Am. Family Mut. Ins. Co., 983 N.E.2d 568 (Ind. 2013).

suing for declaratory judgment[75] or by asserting rescission as an affirmative defense to an insured's lawsuit on the policy[76]

When an insurer learns of a material misrepresentation, it must act promptly to rescind, regardless of whether a loss has occurred.[77] This includes attempting to return all premiums to the insured or making a reasonable effort to do so within a reasonable time after learning there is a basis to rescind.[78] An insurer's failure to act promptly may result in a waiver of the defense, especially when the insurer continues to accept premiums with knowledge of the true facts.[79]

The question whether an insurer has unreasonably delayed in seeking rescission arises only when the insurer learns of facts that *actually* justify rescission—not merely facts that raise the *potential* for rescission.[80] Determining what constitutes a reasonable time period depends on more than merely the length of time elapsed because insurers risk bad faith actions should they act too soon.[81] Courts must provide insurers with an adequate time period to make a good faith investigation to determine whether there is an adequate basis to rescind.[82]

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[75] *See* MEGA Life & Health Ins. Co. v. Pieniozek, 516 F.3d 985, 988 (11th Cir. 2008); Am. Gen. Life Ins. v. Bagley, No. 2:13-cv-00089-RJS, 2013 WL 5916824, at *2 (D. Utah Nov. 4, 2013); Principal Life Ins. Co. v. DeRose, No. 1:08-CV-2294, 2012 WL 910085, at *1 (M.D. Pa. Mar. 16, 2012); Nw. Mut. Life Ins. Co. v. Koch, No. C08-05394BHS, 2011 WL 5570633, at *1 (W.D. Wash. Nov. 16, 2011).

[76] La Plant v. Household Life Ins. Co., No. 12-C-684, 2013 WL 3341054, at *2 (E.D. Wis. July 2, 2013); Eagle Transp., LLC v. Scott, No. 2:11-CV-96-KS-MTP, 2012 WL 1712352, at *5 n.5 (S.D. Miss. May 14, 2012).

[77] Benincasa v. Lafayette Life Ins. Co., No. 10-CV-959 (SRN/TNL), 2011 WL 5967300, at *12 (D. Minn. Nov. 29, 2011); U.S. Life Ins. Co. v. Blumenfeld, 938 N.Y.S.2d 84, at *85-86 (App. Div. 2012). Some states have by statute set strict time limits. For example, Texas mandates that an insurer must rescind an insurance policy within 91 days of discovering the falsity of the representations. *See* Tex. Ins. Code Ann. § 705.005(b) (West 2013); *see also* One Beacon Ins. Co. v. T. Wade Welsh & Assocs., No. H-11-3061, 2012 WL 1155739, at *3 (S.D. Tex. Apr. 5, 2012).

[78] *See Faye Keith Jolly Irrevocable Life Ins. Trust*, 466 F. App'x at 902; *DeRose*, 2012 WL 910085, at *1; *Dodd*, 956 N.E.2d 769, 774.

[79] Am. Gen. Life Ins. Co. v. Katz, 483 F. App'x 609, 610 (2d Cir. 2012); Colonial Nat'l Ins. Co. v. Sorenson Med., Inc., No. 2010-74 (WOB), 2011 WL 6740537, at *12 (E.D. Ky. Dec. 21, 2011). On the other hand, the refunding of premiums paid and the insured's cashing the check, knowing the payment was made with the intent to rescind coverage, can later bar the insured from challenging the rescission. *See* Rideau v. Great W. Life & Annuity Ins. Co., 981 F. Supp. 2d 544, 549, (E.D. La. Nov. 8, 203).

[80] Charter Oak Fire Ins. Co. v. Am. Gen. Capital, Ltd., No. DKC 09-0100, 2011 WL 3511039, at *4 (D. Md. Aug. 9, 2011).

[81] In re Environmental Preservation Assocs., Inc. v. Cohen, No. 10-14421-TJC, 2012 WL 3431640, at *9-10 (Bankr. D. Md. Aug. 14, 2012).

[82] *Id.;* See Principal Life Ins. Co. v. Locker Grp., 869 F. Supp. 2d 359, 365 (E.D.N.Y. 2012); *Charter Oak Fire Ins. Co.*, 2011 WL 3511039, at *4.

B. *Elements Required for Rescinding Coverage*

1. State Law

Each state has its own statutory framework and case law standards an insurer must satisfy before it can rescind a policy. This has resulted in a variety of requirements which determine whether an insurer can properly rescind a life, health or disability insurance policy.

Rescission generally requires four elements: (1) a *misrepresentation* by the applicant that is (2) *material* to the risk to be assumed by the insurer, (3) *knowingly false*, fraudulent or made with a total disregard for its truthfulness, and (4) *reasonably relied on* by the insurer.[83] A few states further require that, for certain types of coverage, the insurer must establish a causal connection between the claim being denied and the information requested on the application.[84] In addition, several states require the insurer to seek a judicial determination that the rescission is valid, either by filing an action seeking rescission or pleading the right to rescind as part of the insurer's defense to a lawsuit filed to enforce a policy.[85]

The insurer has the burden to establish each required element.[86] In some states, the elements must be established by clear and convincing evidence.[87] This standard requires more than the "preponderance of evidence" test normally applied in civil cases, but less than

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[83] *See* Foster v. United of Omaha Life Ins. Co., 442 F. App'x 922, 926 (5th Cir. 2011); *see also* Merritt v. Hub Int'l Sw. Agency, Ltd., No. 1-09–CV–00056–JEC, 2011 WL 4026651, at *6 (N.D. Ga. Sept. 12, 2011); Mass. Mut. Life Ins. Co. v. Jordan, No. 3:10-0016, 2011 WL 1770435, at *3 (S.D. W. Va. May 9, 2011).

[84] *See* Ark. Code Ann. § 23-79-107 (a) (West 2014); Neb. Rev. Stat. Ann. § 44-358 (West 2014); Kan. Stat. Ann. § 40-418 (West 2014) (life insurance); Kan. Stat. Ann. § 40-2205 (West 2014) (accident and sickness); Mo. Ann. Stat. § 376.580 (West 2014) (life); Mo. Ann. Stat. § 376.800 (West 2014) (accident and sickness); Okla. Stat. Ann. tit. 36, §2515 (West 2041) (limited stock life, health and accident insurers only); R.I. Gen. Laws Ann. §27-4-10 (West 2014) (life insurance). Also, Arizona requires a showing of a causal connection under certain circumstances by case law. For a recent and excellent discussion regarding the states requiring a causal relationship between the misrepresentation and the loss, *see* C. Edgar Sentell et al., *The Causal Connection Requirement in Life and Disability Policies; A Reward for Bad Behavior?* 62 Fed'n Def. & Corp. Couns. Q. 306 (2012).

[85] *See* Protective Life Ins. Co. v. Sullivan, 682 N.E.2d 624, 625 (Mass. 1997); Principal Life Ins. Co. v. Erna Altman Ins. Trust, No. 10-CV-1936 (DLT) (RLM), 2012 WL 869303, at *1 (E.D.N.Y. Mar. 13, 2012). A majority of states require the insurer to affirm its rescission through a judicial proceeding. *See* PHL Variable Ins. Co. v. Charter Oak Trust, No. HHDCV106012621S, 2012 WL 2044416, at *4 (Conn. Super. Ct. May 4, 2012).

[86] State Farm Mut. Auto Ins. Co. v. Cockram, No. 2:11-cv-161-FtM-29 DNF, 2012 WL 3155620, at *2 (M.D. Fla. Aug. 3, 2012); Nguyen v. Allstate Co., No. 05-11-01120-CV, 404 S.W.3d 770, 780 (Tex. Ct. App. May 29, 2013).

[87] *See* Scottsdale Ins. Co. v. Tolliver, 261 F. App'x 153, 155 (10th Cir. 2008) (applying Okla. law); Chicago Ins. Co. v. Capwill, No. 1:01CV2588, 2011 WL 6440756, at *4-5 (N.D. Ohio Dec. 21, 2011); Tudor Ins. Co. v. Hellickson Real Estate, 810 F. Supp. 2d 1211, 1216 (W.D. Wash. Aug. 29, 2011); Sadal v. Berkshire Life Ins. Co. of Am., No. 09-612, 2011 WL 292239, at *7 (E.D. Pa. Jan. 31, 2011), *aff'd*, 473 F. App'x 152 (3d Cir. 2012).

certainty "beyond a reasonable doubt" as required in the criminal context. "Clear and convincing evidence" is evidence sufficient to produce in the mind of the trier of fact a firm belief or conviction as to the facts sought to be established.[88] Other states permit rescission when the requirements are satisfied by a preponderance of the evidence.[89] Still others require some level of proof in between.[90] When the application states that answers provided by the applicant are correct to the best of the applicant's knowledge and belief, the burden on the insurer increases to clear proof that the answer is knowingly false.[91] This standard of proof is a heightened one, but is not as exacting as the clear and convincing standard required in certain fraud cases.[92]

a. Misrepresentation/Concealment

A misrepresentation is a false statement of fact or a failure to disclose a fact in response to a specific question.[93] An individual's failure to communicate that which he or she knows is a "concealment."[94] The failure to properly disclose information on the application prevents the insurer from inquiring about these facts so that a proper risk evaluation can be undertaken.[95]

b. Materiality

An insurer is not entitled to rescind a policy unless the information misrepresented or concealed is material.[96] Materiality is determined from the insurer's perspective.[97] A misrepresentation is material if a reasonable insurer would have considered the information

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[88] Churches of Christ in Christian Union v. Evangelical Benefit Trust, No. C2-07-CV-1186, 2009 WL 2146095, at *8 (S.D. Ohio July 15, 2009).

[89] Medicus Ins. Co. v. Todd, No. 05-11-01040-CV, 400 S.W.3d 670, 676 (Tex. Ct. App. 2013).

[90] Banner Life Ins. Co. v. Noel, 861 F. Supp. 2d 701, 707 (E.D. Va. 2012) (clear proof).

[91] *Id.* at 711; Ocean's 11 Bar & Grill, Inc. v. Indem. Ins. Corp., No. 11-61577-CIV, 2012 WL 2675367, at *4 n.9 (S.D. Fla. July 6, 2012); Van Anderson v. Life Ins. Co. of N. Am., No. 4:11cv00050, 2012 WL 1077794, at *9 (W.D. Va. Mar. 30, 2012). The focus then becomes not whether the insured's representations were true but whether, based on his or her knowledge, the insured believed them to be true. Siudut v. Banner Life Ins. Co., No. 12 C 1726, 2013 WL 4659563, at *14 (N.D. Ill. Aug. 30, 2013).

[92] *Noel*, 861 F. Supp. 2d at 711; Ocean's 11 Bar & Grill Inc. v. Indem. Ins. Corp. of D.C., 522 F. App'x 696, 698 (11th Cir. 2013) (heightened standard).

[93] Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898, 914 (8th Cir. 2003); Axis Ins. Co. v. Innovation Ventures, LLC, 737 F. Supp. 2d 685, 689 (E.D. Mich. 2010). A representation is a statement made prior to issuing a policy which the insurer relies on to issue coverage. Unencumbered Assets v. Great Am. Ins. Co., 817 F. Supp. 2d 1014, 1026 (S.D. Ohio 2011). This is an objective determination based on facts known to the insured when the application was completed. *See* Mass. Mut. Life Ins. Co. v. Zaucha, No. 10 C 1978, 2011 WL 3584766, at *3 (N.D. Ill. Aug. 15, 2011).

[94] Hagan v. Cal. Physicians' Serv., No. A130809, 2011 WL 6820396, at *12 (Cal. Ct. App. Dec. 28, 2011).

[95] *Zaucha*, 2011 WL 3584766, at *3.

[96] Johnson v. Metro. Life Ins. Co., 880 N.Y.S.2d 842, 848 (Sup. Ct. 2009) (insurer must prove materiality).

[97] Banner Life Ins. Co. v. Noel, 505 F. App'x 250, 253 (4th Cir. 2012); Salkin v. United Servs. Auto. Ass'n, 835 F. Supp. 2d 825, 829 (C.D. Cal. 2011), *aff'd*, 544 F. App'x 713 (9th Cir. 2013).

important in determining whether or not to insure the applicant.[98] An applicant's prior medical history is naturally and logically the most material matter to a life or health insurance company when it underwrites a risk.[99] Materiality is determined not by the actual loss but only by the probable and reasonable influence of the facts upon the insurer at the time the application is underwritten.[100]

To prove materiality the insurer must establish that its underwriting practices with respect to applicants with similar conditions would reasonably influence the underwriter's judgment in issuing a policy, in estimating the degree or character of the risk or in deciding what premium to charge.[101] The fact an insurer has asked a specific questions in an application is usually sufficient in itself to establish materiality as a matter of law.[102]

Questions arise whether the insurer routinely followed or ignored its own underwriting procedures and whether the requested information was actually important to the company's underwriting decisions with respect to similarly situated applicants. Courts often rely on the testimony of insurance company personnel to prove that truthful answers on the application would have affected the insurer's decision to issue coverage and, if issued, the premium charged.[103] However, an underwriter's affidavit may be insufficient if the underwriter's statements are conclusory.[104] In addition to direct testimony, the insurer should produce an underwriting manual that establishes that the insurer would have analyzed the insured's application differently had it known the insured had a certain medical condition or occupation or engaged in certain social behaviors.[105]

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[98] *Noel*, 861 F. Supp. 2d at 712; Am. Gen. Life Ins. Co. v. Bolden, No. 10 Civ 712 (LTS) (GWG), 2011 WL 3278910, at *2-3 (S.D.N.Y. July 27, 2011).

[99] S.B. v. United of Omaha Life Ins. Co., No. 13-1463, 2013 WL 2915973, at *5 (E.D. Pa. June 13, 2013); Kennedy v. N. Am. Co. for Life & Health Ins., No. 08-2175-JWL, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009).

[100] *Noel*, 505 F. App'x at 253; One Beacon Ins. Co. v. T. Wade Welsh & Assocs., No. H-11-3061, 2012 WL 1155739, at *3 (S.D. Tex. Apr. 5, 2012); *Salkin*, 835 F. Supp. 2d at 829.

[101] *See Johnson*, 880 N.Y.S.2d at 848; Mass. Mut. Life Ins. Co. v. Jordan, No. 3:10-0016, 2011 WL 1770435, at *4 (S.D. W. Va. May 9, 2011); *but see* Greves v. Ohio State Life Ins. Co., 821 P.2d 757, 763 (Ariz. Ct. App. 1991) (interpreting Arizona's rescission statute to prohibit rescission if insurer would have issued same policy at higher premium).

[102] Century Sur. Co. v. 350 W.A., LLC, No. 05-CV-1548-L(BGS), 2011 WL 4506981, at *4 (S.D. Cal. Sept. 28, 2011); Tudor Ins. Co. v. Hellickson Real Estate, 810 F. Supp. 2d 1211, 1216-17 (W.D. Wash. Aug. 29, 2011); *Jordan*, 2011 WL 1770435, at *4.

[103] Siefers v. Pac. Life Assur. Co., 461 F. App'x 652, 655-55 (9th Cir. 2011); Kieszkowski v. Personal Care Ins. of Ill., Inc., No. 09 C 01936, 2011 WL 3584324, at *4 (N.D. Ill. Aug. 12, 2011); Ashkenazi v. AXA Equitable Life Ins. Co., 937 N.Y.S.2d 215, 215 (App. Div. 2012).

[104] *Johnson*, 880 N.Y.S.2d at 847-49; *Salkin*, 835 F. Supp. 2d at 831.

[105] Am. Gen. Life Ins. Co. v. Schoenthal, 555 F.3d 1331, 1341 (11th Cir. 2009); Mega Life & Health Ins. Co. v. Pieniozek, 516 F.3d 985, 990-91 (11th Cir. 2008); Siudut v. Banner Life Ins. Co., No. 12 C 1726, 2013 WL 4659563, at *4 (N.D. Ill. Aug. 30, 2013).

Depending on the state, materiality is considered to be either an objective or a subjective standard of conduct of a prudent insurer.[106] While materiality is generally a mixed question of law and fact, a court may decide the issue as a matter of law utilizing the insurer's practice regarding similar risks, underwriting manuals and testimony by a qualified employee.[107]

c. Intent to Deceive

(1) Introduction

The most difficult issue facing insurers in rescission cases is establishing, when required, the requisite knowledge or intent to deceive by the insured. This is so because what constitutes a knowing misrepresentation and intent to deceive varies significantly from state to state.

There is a distinction between misrepresentation and fraud. Misrepresentation is but one element of fraud.[108] This distinction is particularly important when dealing with insurance applications.

A number of states do not require an insurer to establish an actual intent to deceive on the part of an insured to rescind coverage; in these states, a material misrepresentation, even if innocently made, will suffice.[109] The insured's good faith in completing the application is not material.[110] In these situations "[w]hether the applicant intended to mislead or knew of the falsity is irrelevant. False representations concerning a material fact, which mislead, will avoid an insurance contract, like any other contract, regardless of whether the misrepresentation was innocent or made with fraudulent design."[111]

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[106] *Schoenthal*, 555 F.3d at 1340 (objective); *Century Sur. Co.*, 2011 WL 4506981, at *4 (subjective); *Jordan*, 2011 WL 1770435, at *4 (objective); Hagan v. Cal. Physicians' Serv., No. A130809, 2011 WL 6820396, at *10-11 (Cal. Ct. App. Dec. 28, 2011) (subjective).

[107] *Noel*, 861 F. Supp. 2d at 712; *Jordan*, 2011 WL 1770435, at *6; *Johnson*, 880 N.Y.S.2d at 846.

[108] *See* Omni Ins. Grp. v. Lake Poage, No. 92A03-1105-CT-208, 966 N.E.2d 750, 754 (Ind. Ct. App. 2012). Misrepresentation is considered to be something other than innocent misstatement. *See* PHL Variable Ins. Co. v. Sheldon Hathaway Family Ins. Trust, No. 2:10-cv-67, 2013 WL 6230351, at *1 (D. Utah Dec. 2, 2013). Fraud is readily understood by the ordinary person; it is not a technical term. Kennedy v. North Am. Co. for Life & Health Ins., No. 08-2175-JWL, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009).

[109] Sec. Mut. Ins. Co. v. Perkins, 927 N.Y.S.2d 189, 190 (App. Div. 2011); Pope v. Mercury Indem. Co. of Ga., 677 S.E.2d 693, 697 (Ga. Ct. App. 2009); Love v. Liberty Ins. Corp., No. 11-10740, 2011 WL 5143383, at *2 (E.D. Mich. Oct. 31, 2011); N. Wind Fabrications, Inc. v. Pruco Life Ins. Co., No. 1:09cv682-LG-RHW, 2010 WL 4007315, at *3 (S.D. Miss. Oct. 12, 2010).

[110] *See* Fortney v. Lincoln Nat'l Life Ins. Co., No. 1:11-CV-4337-RWS, 2013 WL 3831672, at *7 (N.D. Ga. July 15, 2013); Johnson v. Household Life Ins. Co., No. 5:11-CV-301-BR, 2012 WL 5336959, at *4 (E.D.N.C. Oct. 26, 2012).

[111] *Omni Ins. Grp.*, 966 N.E.2d at 754 n.4.

Other states require an insurer seeking to rescind to establish either that the false statement was made with an actual intent to deceive or that it materially affected either the acceptance of the risk or the degree of hazard assumed by the insurer.[112] Still other states say that a misrepresentation is one that is known by the insured to be false when made, though not necessarily with a conscious intent to defraud.[113]

Applying the most stringent test, some states require the insurer to prove that the applicant made the false statement knowingly or knowingly concealed the true facts with an intent to deceive.[114] When an insured has made a misrepresentation regarding material facts particularly within his or her knowledge, the finder of fact may, from the mere occurrence of the misrepresentation, determine that it was knowingly made with the requisite intent to deceive.[115]

Fraud occurs when "someone knowingly makes a materially false representation or recklessly makes a materially false representation without regard to its veracity with the intent that the statement be relied on by another party and that other party suffers an injury."[116] A "reckless disregard for the truth" occurs when "the applicant entertains serious doubts as to the truth" of the statements made.[117] Courts set a high bar for the insurer to establish a knowing, intentional deception.[118]

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[112] Kieszkowski v. Personal Care Ins. of Ill., 2011 WL 3584324, at *3 (N.D. Ill. Aug. 12, 2011); Chowdhury v. United of Omaha Ins. Co., No. 1:07-cv-00095 CW, 2009 WL 1851005, at *3 (D. Utah June 26, 2009).

[113] Yang v. Western-Southern Life Assur. Co., 713 F.3d 429, 433 (8th Cir. 2013); Silver v. Colorado Cas. Ins. Co., 219 P.3d 324, 328 (Colo. App. 2009); Siefers v. PacifiCare Life Assur. Co., 461 F. App'x 652, 654 n.1 (9th Cir. 2011).

[114] *See* Foster v. United of Omaha Life Ins. Co., 442 F. App'x 922, 926 (5th Cir. 2011); Nat'l Independent Truckers Ins. Co. v. Gadway, 860 F. Supp. 2d 946, 951 (D. Neb. 2012); Benson v. Leaders Life Ins. Co., No. 5:10-1600-MBS, 2012 WL 6585123, at *3 (Okla. Dec. 18, 2012).

[115] Kutlenios v. UnumProvident Corp., 475 F. App'x 550, 553 (6th Cir. 2012); *Gadway*, 860 F. Supp. 2d at 953 (quoting Lowery v. State Farm Mut. Auto Ins. Co., 421 N.W.2d 775, 779 (Neb. 1988)).

[116] *Kutlenios*, 475 F. App'x at 553. A reckless disregard for the truth may prove falsity but it is not sufficient to establish an "intent to deceive." Busch v. Ohio Nat'l Life Assur. Corp., No. 5:09-CV-355-D, 2011 WL 902298, at *4 (E.D.N.C. Mar. 14, 2011).

[117] Chism v. Protective Life Ins. Co., 234 P.3d 780, 791-92 (Kan. 2010).

[118] Scottsdale Ins. Co. v. Tolliver, 261 F. App'x 153, 162 (10th Cir. 2008); *Gadway*, 860 F. Supp. 2d at 952. Depending on the particular state law, intent to deceive can be decided as a matter of law. Bennett v. Am. Hallmark Ins. Co., , 2011 WL 2936003, at *4 (D.S.C. July 18, 2011). Otherwise, it is an issue for the trier of fact. *Benson*, 2012 WL 6585123, at *3.

(2) Legal Fraud

Those states mandating proof of actual or legal fraud as a prerequisite to rescission require the insurer to establish a material misrepresentation of a presently existing or past fact made by the insured with knowledge it is untrue and with the intent to deceive so the insurer relies to its detriment on the misrepresentation.[119] The key element is that the misrepresentation must be knowingly made.[120] The applicant must be reasonably chargeable with knowledge that the facts omitted or misrepresented were within the scope of the questions asked on the application.[121] Fraud is never presumed; rather, it must be proven by clear and convincing evidence.[122] Because subjective intent is rarely subject to summary judgment, the issue of intent to deceive is usually a question for the trier of fact.[123]

Courts acknowledge that there are inherent difficulties in proving intent, so strict proof of fraud is not always required. Intent often is determined from all the attending circumstances which indicate the insured's knowledge of the falsity of the representation made in the application.[124] For example, evidence of the severity of the insured's undisclosed health problems strongly indicates that the application representations were knowingly false.[125]

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[119] *See* Crosby v. Life Ins. Co. of Sw., No. CV-10-00064-PHX-GMS, 2010 WL 5364044, at *3 (D. Ariz. Dec. 21, 2010). In Arizona "legal" fraud is distinguished from "actual" fraud. The former does not require an intent to deceive, but the latter does. *See also* Loza v. Am. Heritage Life Ins. Co., No. CV09-118 PHX DCG, 2010 WL 716322, at *2 (D. Ariz. Feb. 25, 2010), *rev'd on other grounds*, 434 F. App'x 687 (9th Cir. 2011).

[120] Foster v. United of Omaha Life Ins. Co., 442 F. App'x 922, 926 (5th Cir. 2011); Van Anderson v. Life Ins. Co. of N. Am., No. 4:11cv00050, 2012 WL 1077794, at *11 (W.D. Va. Mar. 30, 2012); Tudor Ins. Co. v. Hellickson Real Estate, 810 F. Supp. 2d 1211, 1217 (W.D. Wash. Aug. 29, 2011).

[121] Wetherspoon v. Columbus Life. Ins. Co., No. 11-CV-3830, 2013 WL 241238, at *5 (N.D. Ill. Jan. 18, 2013).

[122] *See supra* text accompanying notes 87-88. *See also* Churches of Christ in Christian Union v. Evangelical Benefit Trust, No. C2-07-CV-1186, 2009 WL 2146095, at *8 (S.D. Ohio July 15, 2009).

[123] *Benson*, 2012 WL 6585123, at *3; *but see* Bennett v. Am. Hallmark Ins. Co., No. 5:10-1600-MBS, 2011 WL 2936003, at *4 (D.S.C. July 18, 2011) (noting that, if there is only one inference, intent to deceive can be decided as a matter of law).

[124] Miguel v. Metro. Life Ins. Co., 200 F. App'x 961, 967 (11th Cir. 2006). An individual applying for insurance "must make a reasonable use of his facilities in endeavoring to understand and answer the questions asked of him and his answers must be made in good faith." La Plant v. Household Life Ins. Co., No. 12-C-684, 2013 WL 3341054, at *4 (E.D. Wis. July 2, 2013) (quoting Southard v. Occidental Life Ins. Co. of Cal., 142 N.W.2d 844 (Wis. 1966)).

[125] Reid-Smith v. Globe Life & Accident Ins. Co., No. 7:12cv00393, 2012 WL 6096499, at *1 (W.D. Va. Dec. 7, 2012); Sadal v. Berkshire Life Ins. Co. of Am., No. 09-612, 2011 WL 292239, at *7 (E.D. Pa. Jan. 31, 2011), *aff'd* , 473 F. App'x 152 (3d Cir. 2012); Kennedy v. N. Am. Co. for Life & Health Ins., No. 08-2175-JWL, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009).

Similarly, when an insured makes representations he or she knows to be false, courts presume intent to deceive.[126] This presumption is not overcome by the insured's unsupported denial of fraudulent intent.[127]

Innocent misrepresentations—i.e., those made due to ignorance, mistake or negligence—are not sufficient. An applicant's failure to disclose a specific medical condition of which he or she was ignorant will not justify rescission.[128] A layman is excused if he or she failed to understand the meaning of certain medical terms and for that reason failed to disclose some fact in the requested medical history. The rationale is that because laypersons lack the same level of knowledge or understanding as that possessed by doctors and other experts, it is unfair to permit rescission based on information the applicant did not know or did not fully understand.[129] In those situations, the applicant does not know that the information he is providing is false.[130]

This does not, however, excuse an applicant who fails to read the application prior to signing it. An individual is required not only to respond accurately and fully to all questions but also to use reasonable diligence to be sure that the responses are correctly written.[131] Signing the application without reading it is evidence of a reckless disregard for the truth of the representations set forth in the application.[132] This duty is not strictly enforced when the insurer's agent completes the application and either knowingly enters false information or fails to ask the applicant for all requested information. In that case, the insurer cannot rescind coverage,[133] even if the applicant could have discovered the misrepresentation by reading the application.[134]

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[126] Kim v. Allstate Ins. Co., 223 P.3d 1180, 1189 (Wash. Ct. App. 2009); *La Plant*, 2013 WL 3341054, at *3-4; S.B. v. United of Omaha Life Ins. Co., No. 13-1463, 2013 WL 2915973, at *4 (E.D. Pa. June 13, 2013); Tudor Ins. Co. v. Hellickson Real Estate, 810 F. Supp. 2d 1211, 1217 (W.D. Wash. 2011).

[127] *Kim*, 223 P.3d at 1189; Mt. Vernon Fire Ins. Co. v. 211 Bar & Grill, Inc., 2011 WL 4565431, at *3 (E.D. Wash. Sept. 29, 2011); *Tudor Ins. Co.*, 810 F. Supp. 2d at 1217.

[128] Hagan v. Cal. Physicians' Serv., No. A130809, 2011 WL 6820396, at *11 (Cal. Ct. App. Dec. 28, 2011); Shokrian v. Pac. Specialty Ins. Co., 2009 WL 2488881, at *2 (Cal. Ct. App. 2009).

[129] *Shokrian*, 2009 WL 2488881, at *7. Questions on an application are viewed from a layperson's point of view. *La Plant*, 2013 WL 3341054, at *2.

[130] *Shokrian*, 2009 WL 2488881, at *7.

[131] *See* West Coast Life Ins. Co. v. Hoar, 558 F.3d 1151, 1157 (10th Cir. 2009); Warkentin v. Federated Life Ins. Co., No. 1:10cv0021 DLB, 2012 WL 1110375, at *2 (E.D. Cal. Mar. 28, 2012); Lawhon v. Mountain Life Ins. Co., No. E2011-00045-COA-R3-CV, 2011 WL 5829726, at *4 (Tenn. Ct. App. Nov. 21, 2011).

[132] Chism v. Protective Life Ins. Co., 234 P.3d 780, 791-92 (Kan. 2010).

[133] Barrera v. Am. Nat'l Prop. & Cas. Co., No. 12-cv-00413-WYD-MEH, 2013 WL 5426349, at *8 (D. Colo. Sept. 27, 2013); Bennett v. Am. Hallmark Ins. Co., No. 5:10-1600-MBS, 2011 WL 2936003, at *8 (D.S.C. July 14, 2011). The reverse is also true: An insured acting in collusion with the agent to provide false information on the application does not bind the insurer. Mass. Mut. Life Ins. Co. v. Zaucha, No. 10 C 1978, 2011 WL 3584766, at *4 (N.D. Ill Aug. 15, 2011).

[134] *Chism*, 234 P.3d at 783; Certain Interested Underwriters at Lloyd's London v. Cooper, No. 3:10-cv-01382-JFA, 2012 WL 554577, at *4 (D.S.C. Feb. 21, 2012).

(3) Equitable Fraud

New Jersey law draws a distinction between legal and equitable fraud. Equitable fraud requires the insurer to establish the material misrepresentation of a presently existing fact, the applicant's intent that the insurer rely on it and detrimental reliance.[135]

An insurer may rescind for equitable fraud where the false statements on the application materially affected either the acceptance of the risk or the hazard assumed by the insurer.[136] No actual intent to deceive is required. Even innocent misrepresentations may constitute equitable fraud.[137] New Jersey requires that proof of equitable fraud be established by clear and convincing evidence.[138] A subjective misrepresentation can be considered to be equitable fraud only if it was knowingly false.[139] This rule has two qualifications. First, it does not apply to persons capable of appreciating the significance of the misrepresented or omitted facts.[140] Second, in misrepresenting or omitting material facts, the applicant must have acted in good faith.[141]

2. ERISA

Group coverage, such as that provided by employers, is in most instances issued without the necessity of underwriting and rescission is not an issue. But not all policies subject to the Employee Retirement Income Security Act (ERISA) waive the individual's requirement to qualify medically.[142] ERISA, unlike state laws, is silent on the issue of rescission. Because there is no statutory provision governing rescission in response to misrepresentations in a life or health insurance application, federal common law controls.[143] Courts applying federal common law permit equitable rescission of an ERISA-governed insurance policy obtained through material misrepresentations or omissions.[144]

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[135] Conseco Life Ins. Co. v. Smith, No. 2:11-cv-3716 (SDW) (MCA), 2013 WL 3285065, at *6 (D.N.J. June 26, 2013).

[136] *Conseco Life Ins. Co.*, 2013 WL 3285065, at *6; Am. Gen. Life Ins. Co. v. Oberlander Planning Trust, No. Civ. 10-1902 (WHW), 2011 WL 5040670, at *4 (D.N.J. Oct. 24, 2011); Grande Leather & Fur L.L.C. v. Bond, No. A-3854-08T3, 2011 WL 1661072, at *5 (N.J. Super. Ct. App. Div. May 4, 2011).

[137] Prudential Ins. Co. of Am. v. Goldman Sachs & Co., No. 12-6590 (SDW)(MCA), 2013 WL 1431680, at *7 (D.N.J. Apr. 9, 2013); Allianz Life Ins. Co. of America v. Estate of Bleich, No. 08-668 (SDW) (MCA), 2012 WL 714686, at *11-12 (D.N.J. Mar. 5, 2012).

[138] *Conseco Life Ins. Co.*, 2013 WL 3285065, at *6.

[139] *Id.*

[140] Shokrian v. Pac. Specialty Ins. Co., 2009 WL 2488881, at *7 (Cal. Ct. App. 2009).

[141] *Id*.

[142] Guardian Life Ins. Co. of Am. v. Gabrielian & Assocs., No. CV 12-632-JFW (MANx), 2012 WL 6618268, at *5 (C.D. Cal. Dec. 19, 2012); Van Anderson v. Life Ins. Co. of N. Am., No. 4:11cv00050, 2012 WL 1077794, at *9 (W.D. Va. Mar. 30, 2012).

[143] Shipley v. Ark. Blue Cross & Blue Shield, 333 F.3d 898, 902 (8th Cir. 2003).

[144] *Id*.; Sec. Life Ins. Co. of Am. v. Meyling, 146 F.3d 1184, 1191 (9th Cir. 1998).

When developing federal common law, courts may look to state law for guidance.[145] The issue regarding which law applies—federal or state—is important because of the various state requirements. A particular state's law governing rescission does not automatically control. It must be consistent with the federal common law approach.[146] Under ERISA, knowing misstatements or omissions are material and support rescission where knowledge of the true facts would have influenced the insurer's decision to accept the risk or its assessment of the premium amount.[147] In *Shipley v. Arkansas Blue Cross & Blue Shield*, the court acknowledged that some states require proof of fraudulent intent or bad faith on the part of the insured, but noted that the majority of states permit rescission merely on the basis of a misrepresentation of material facts made knowingly in an application for an ERISA-governed insurance policy.[148]

This point is illustrated in *Van Anderson v. Life Insurance Co. of North America*.[149] There, the insurer sought to rescind an ERISA-governed voluntary supplemental life insurance policy. The health application requested information regarding diagnosis or treatment within the previous five years for any condition affecting the stomach or pancreas and regarding anxiety and alcohol or drug abuse.[150] The insured, prior to applying for coverage, had undergone a battery of medical tests, had a history of alcohol abuse, and suffered from acute pancreatitis. He also had a history of gastroesophageal reflux and heartburn, and was taking prescription medication for anxiety. None of these conditions was disclosed on the application.[151]

Under Virginia law, which the court found to be consistent with federal common law, an insurer need not prove the insured had an actual intent to deceive in order to rescind the policy.[152] The insurer must show only that the applicant was or should have been aware of the facts in question based on the circumstances.[153] A knowing misrepresentation is established by showing that the insured was aware he needed medical care because he sought that care, received a diagnosis from a medical professional, and was prescribed medication thereafter. It was obvious the insured knew about the true condition of his health. His physicians had advised him of his medical conditions, and he knew he was taking medication for anxiety

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[145] *Shipley*, 333 F.3d at 902.

[146] *Id.* at 903; Kieszkowski v. Personal Care Ins. of Ill., Inc., No. 09 C 01936, 2011 WL 3584324, at *4 (N.D. Ill. Aug. 12, 2011).

[147] *Gabrielian & Assocs.*, 2012 WL 6618268, at *5.

[148] *Shipley*, 333 F.3d at 903.

[149] No. 4:11cv00050, 2012 WL 1077794 (W.D. Va. Mar. 30, 2012).

[150] *Id.* at *6.

[151] *Id.* at *3.

[152] *Id.* at *9.

[153] *Id.* at *11.

and undergoing numerous medical tests. The court found it "fairly clear that [the insured's] misrepresentations were made knowingly."[154] Rescission was permitted.[155]

3. Application Questions

The more specific the application question and the more serious the medical condition not disclosed, the easier it is for the insurer to establish fraud. When the application asks clear and straightforward questions, the applicant is required to provide equally clear and straightforward responses.[156] The misrepresentation should concern objective facts about doctor visits, hospital confinements and concrete diagnoses of which the insured was undoubtedly aware and that were not reasonably open to interpretation.[157]

An insured's failure to disclose conditions specifically asked about on the application supports a finding that the insured did so with knowledge of the falsity of the information provided.[158] So too, the fact the insured does not merely fail to provide any specific medical history, but also mentions a specific insignificant injury or minor illness and specific dates of treatment, is evidence that the failure to disclose a more serious medical condition was intentional or at least done with reckless disregard for the truth.[159] Similarly, multiple false statements on an application establish that the statements were made with the deliberate and fraudulent intent to deceive.[160]

Once such a showing is made, the burden shifts to the insured to establish an honest motive or an innocent intent.[161] The insured's bare assertion that he or she did not intend to deceive the insurer is not sufficient evidence of good faith, and the presumption supports a finding for the insurer.[162]

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[154] *Id*.

[155] *Id*.

[156] United of Omaha Life Ins. Co. v. Halsell, 2010 WL 376428, at *3 (W.D. Tex. 2010).

[157] *See* Kutlenios v. UnumProvident Corp., 475 F. App'x 550, 553 (6th Cir. 2012); Kennedy v. North Am. Co. for Life & Health Ins., No. 08-2175-JWL, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009). For example, longstanding and serious medical conditions such as cirrhosis, liver failure, hepatitis, diabetes and hypertension may support the insurer's argument that the insured's failure to disclose these conditions was done with knowledge of their falsity. *See* Johnson v. Metro. Life Ins. Co., 880 N.Y.S.2d 842, 845, 850 (Sup. Ct. 2009); *see also* Wilton Reassur. Life Co. v. Lister, No. 08-CV-085-TCK-PJC, 2009 WL 483197, at *2 (N.D. Okla. Feb. 25, 2009) (same re metastatic esophageal cancer).

[158] S.B. v. United of Omaha Life Ins. Co., No. 13-1463, 2013 WL 2915973, at *4 (E.D. Pa. June 13, 2013).

[159] *Kennedy*, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009).

[160] Chicago Ins. Co. v. Capwill, No. 1:01CV2588, 2011 WL 6440756, at *4 (N.D. Ohio Dec. 21, 2011)

[161] Kim v. Allstate Ins. Co., 223 P.3d 1180, 1189 (Wash. Ct. App. 2009).

[162] Mt. Vernon Fire Ins. Co. v. 211 Bar & Grill, Inc., 2011 WL 4565431, at *3 (E.D. Wash. Sept. 29, 2011); Tudor Ins. Co. v. Hellickson Real Estate, 810 F. Supp. 2d 1211, 1217 (W.D. Wash. 2011).

These points are illustrated in *Sadal v. Berkshire Life Insurance Co. of America*.[163] The insured, a licensed pharmacist, began treatment in 2002 with a licensed clinical social worker for abusing opiates (Percocet, Oxycontin, Vicodin, Lorcet, Xanax and Soma). He attended individual and group sessions for a substance abuse disorder.

In 2005, the insured purchased disability coverage, responding "no" to application inquiries regarding the use of stimulants, hallucinogens, narcotics or other controlled substances; counseling or treatment for alcohol or drug abuse; and treatment, consultation or counseling for anxiety, depression, nervousness, stress, mental or nervous disorder or other emotional disorder.[164]

The insured was injured during an armed robbery in one of his pharmacies, resulting in the amputation of the three middle fingers of his left hand and injury to the two remaining fingers. When taken to a hospital for treatment, he disclosed that he had a history of taking "unprescribed" narcotics.[165] He thereafter resumed individual therapy (along with his ongoing group therapy) for post-traumatic stress disorder. During the first session, the social worker noted in her chart that the insured told her he lied about his drug treatment on his insurance application.

The insured then submitted a disability claim. The claims adjuster obtained medical records and learned the insured had participated in about 57 individual and 78 group therapy sessions between 2002 and the date the application was signed on January 18, 2005.[166] The insurer sought to rescind on March 27, 2009, relying on the policy's contestability fraud exception since more than two years had elapsed since the policy's issuance. In this circumstance, the insurer was required to prove facts justifying rescission by clear and convincing evidence.[167]

The insurer satisfied these requirements.[168] The company's underwriting guidelines stated that coverage would not be issued to anyone who abused controlled substances within five years preceding the application date, a policy that was confirmed by an underwriter in deposition.[169]

The insured alleged he did not really notice these questions when he "breezed though" the application and that he was "embarrassed" because of the stigma associated with the conduct in question.[170] However, the insured had signed the application attesting that his

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[163] No. 09-612, 2011 WL 292239 (E.D. Pa. Jan. 31, 2011), *aff'd,* 473 F. App'x 152 (3d Cir. 2012).

[164] *Id.* at *2.

[165] *Id*. at *3.

[166] *Id.* at *5.

[167] *Id.* at *7.

[168] *Id.* at *10.

[169] *Id.* at *9.

[170] *Id.* at *2.

responses were correct and also met with a medical examiner during the application process where he again denied drug use or treatment. Consequently, these court rejected the insured's explanations.[171]

These application questions were straightforward, and the insured knowingly answered them falsely.[172] Moreover, the evidence established numerous individual and group therapy sessions for drug dependency and stress,[173] and the plaintiff admitted the falsity of his representations.[174] On the basis of this evidence, the district court judge ruled as a matter of law these statements had been fraudulently made.[175]

In *American General Life Insurance Co. v. Bolden*,[176] the insurer filed a declaratory judgment action seeking to void a $500,000 life insurance policy. The policy was issued at the "preferred plus" rate, the best rate offered by American General.[177] The insured died one year later from renal cancer.

The application asked "in the past 10 years, has the Proposed Insured . . . been advised to have any diagnostic test, hospitalization, or treatment that was NOT completed?"[178] The insured said "no."[179] However, two months before completing the application, the insured had sought treatment from a urologist for gross hematuria (visible blood in the urine), and the doctor had ordered further testing and told the insured to return for another visit.[180] Additionally, the insured's internist had ordered additional tests, including cytology, which is an element of cancer screening. The insured never completed these tests.

The insurer's underwriting guidelines stated that hematuria "present[s] a significant underwriting challenge," and recommended a "thorough assessment" of the applicant before accepting him or her as a preferred policyholder.[181] American General would not have issued the policy without additional follow-up testing had it known about the uncompleted diagnostic test.

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[171] *Id.* at *10.

[172] *Id.* at *8.

[173] *Id*.

[174] *Id.* at *9.

[175] *Id.* at *10.

[176] No. 10 Civ.712 (LTS) (GWG), 2011 WL 3278910 (S.D.N.Y. July 27, 2011).

[177] *Id.* at *1.

[178] *Id*.

[179] *Id*.

[180] *Id.* at *3.

[181] *Id.*

The application also asked whether "the Proposed Insured ever . . . sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs?"[182] The insured responded "no."[183] However, the insured's doctor had told him to stop drinking alcohol. The insurer's underwriting guidelines stated that such medical instructions "would have raised red flags" requiring additional information.[184]

The court found the cytology test to be material and that American General would not have issued the policy without further testing. So, too, the failure to disclose alcohol counseling was material: Had the insured disclosed his doctor's instruction to stop drinking alcohol, American General would not have offered the policy without the insured's completing an additional questionnaire. Based on these material misrepresentations, American General was entitled to rescind as a matter of law.[185]

However, the more open-ended the application question, the more difficult it becomes to establish the insured knowingly made a false statement. Rescission cannot be based on responses to ambiguous application questions.[186] "A question is ambiguous when it is susceptible to two reasonable interpretations, one in which a negative response would be correct and one in which an affirmative response would be correct."[187] The interpretation of questions in an insurance application is a question of law for the court's determination.[188] Ambiguity is construed against the insurer.[189]

For example in *Weekes v. Ohio National Life Assurance Corp.*,[190] the insured stated on the application that the current policy was to replace a prior policy. However, when the insured died a few months later, the prior policy was still in force.[191] The insurer sought to rescind on the basis that it expected the prior policy to have been cancelled, and the insured's failure to do so constituted a misrepresentation. The court disagreed.[192] If the insurer wanted

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[182] *Id.* at *1.

[183] *Id*.

[184] *Id.* at 2.

[185] *Id*.

[186] Ocean's 11 Bar & Grill, Inc. v. Indem. Ins. Corp., No. 11-61577-CIV, 2012 WL 2675367, at *4 n.9 (S.D. Fla. July 6, 2012).

[187] Riversource Life Ins. Co. v. Amy Plumbing, Heating & Cooling Inc., No. 12 C 1388, 2013 WL 1110922, at *3 (N.D. Ill. Mar. 15, 2012); La Plant v. Household Life Ins. Co., No. 12-C-684, 2013 WL 3341054, at *8 (E.D. Wis. July 2, 2013).

[188] *See* Hagan v. Cal. Physicians' Serv., No. A130809, 2011 WL 6820396, at *8 (Cal. Ct. App. Dec. 28, 2011).

[189] Farm Bureau Life Ins. Co. v. Holmes Murphy & Assocs., Inc., 831 N.W.2d 129, 133-34 (Iowa 2013).

[190] No. 1:10-cv-566-BLW, 2011 WL 5835596 (D. Idaho Nov. 21, 2011).

[191] *Id.* at *2.

[192] *Id.* at *4.

to predicate issuance of its policy on the actual termination of the prior policy, it could have specifically asked that question. "Replacement" of the old policy did not necessarily mean simultaneous replacement.[193]

In another case, *Loza v. American Heritage Life Insurance Co.*, plaintiff Loza applied for a for a cancer insurance policy, responding "no" to the question "[i]s any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer . . . ?"[194] Prior to completing the application, Loza had visited his doctor for urinary problems. In addition, he had a past history of an enlarged prostate and his father had been diagnosed with prostate cancer.

Loza's doctor determined that Loza's prostate was enlarged and ordered a PSA (prostate specific antigen) test. Although considered a routine screening test in men, a PSA test is also used to indicate a number of prostate and urinary tract infections. Loza's PSA was elevated, and he was referred to a urologist.[195]

Several months after the policy was issued, Loza was diagnosed with prostate cancer. The insurer conducted an investigation and, based on the negative response to the application question quoted above, rescinded coverage. The insurer considered the PSA test to be a diagnostic test for cancer.[196]

The question before the court was whether a PSA test constituted a "diagnostic test" within the meaning of the application.[197] The term was not defined in the policy. The insurer argued that the term should be defined as any test that is part of the diagnostic process used to identify cancer. The court noted that, although a PSA test is a diagnostic test, it does not directly diagnose cancer. The relevant question was not whether the PSA test generally can be described as diagnostic test, but "how the language of the policy applies to the specific facts of the case."[198]

The PSA is used as a screening test in conjunction with other examination results to evaluate whether a biopsy of the prostate is needed.[199] In fact, this test is recommended for all men of a certain age, regardless of symptoms.[200] Here, the insured's physical symptoms and medical history indicated a heightened potential for prostate cancer but his doctor did not tell him he was being tested for cancer, and the insured stated he did not know what the test was for.[201] Under Arizona law, the insurer must establish that the insured made a

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[193] *Id.*

[194] *Id.* at *1.

[195] *Id.*

[196] *Id.*

[197] *Id.* at *3.

[198] *Id.* (quoting Emp'rs Mut. Cas. Co. v. DGG & CAR, Inc., 183 P.3d 513, 515 (Ariz. 2008)).

[199] 434 F. App'x at 689.

[200] *Id.* at 690.

[201] *Id.*

misrepresentation in the application.[202] Because both the insured's and insurer's arguments were reasonable, the policy was ambiguous and construed against the insurer.[203]

In *Brondon v. Prudential Insurance Co. of America*, the insurer denied benefits under a $50,000 ERISA-governed life insurance policy due to alleged misrepresentations on the application.[204] According to the insured, "I have never been diagnosed with, or taken medication for, any of the following: *heart trouble* . . . ."[205] Medical records indicated the insured suffered from "mild aortic sclerosis and mitral valve prolapse with mild mitral insufficiency."[206]

The court found the term "heart trouble" to be ambiguous. "Heart trouble" is not a recognized diagnosis in the medical field,[207] and the question did not ask whether the applicant suffered from a specific disorder or disease (such as high blood pressure, cancer, diabetes, etc.).[208] The insured's denial of "heart trouble" therefore not be used to support a misrepresentation regarding the insured's health.[209]

> [O]nly Prudential would be allowed to define what constitutes "heart trouble"; would be allowed to do so after the claim is made; and would be allowed to change and amend the definition on a case by case basis for the purpose of contesting and rescinding any policy in circumstances where there is retroactive evidence of any heart abnormality, no matter how common or benign, that the applicant may have known of. Such a holding would be manifestly unjust, and would defeat the purpose of protecting a beneficiary's right to a fair consideration of his or her claim for benefits.[210]

Moreover, the court noted, mitral valve prolapse is often harmless and treatment is not required.[211] Here, there was nothing to show that the insured's heart conditions affected her heart function; and, according to her doctor, these conditions were of "no clinical significance."[212] The insured did not take any medication, nor were her daily activities restricted.[213]

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[202] *Id*.

[203] *Id*.

[204] No. 09-CV-6166T, 2010 WL 4486333, at *1 (W.D.N.Y. Nov. 9, 2010).

[205] *Id.*

[206] *Id.* at *2.

[207] *Id.* at *7.

[208] *Id.* at *6-7.

[209] *Id.* at *7.

[210] *Id.* at *9.

[211] *Id.* at *9 n.3.

[212] *Id.* at *10.

[213] *Id*.

4. Medical Testimony

Finally, testimony by the insured's treating physician can be very important when an insurer must prove intent to deceive. When an insured represents on the application that he or she has not been diagnosed or treated for a particular medical condition, testimony that the treating physician told the insured about the diagnosis can establish that the insured acted knowingly and with the requisite intent or reckless disregard.[214]

In *Kennedy v. North American Co. for Life & Health Insurance*, for example, the insured, Kennedy, applied for and was issued a term life insurance policy.[215] He allowed the policy to lapse and then applied for reinstatement.[216] In both the original and subsequent application, Kennedy stated that he had had only a routine physical with no adverse findings. He also answered "no" to the question whether he had been diagnosed with or treated by a medical professional for, among other conditions, a stroke or cancer.[217] In fact, Kennedy had been diagnosed and treated for a stroke, and his doctor testified that Kennedy was well aware of this diagnosis.[218] Accordingly, Kennedy's misrepresentations on the application were not made in good faith, but knowingly and with the required intent or reckless disregard.[219] The court granted the insurer's summary judgment motion seeking to affirm its rescission.[220]

The court reached the opposite conclusion in *Neiman v. American International Group, Inc*.[221] In that case, the insured died of lung cancer within the two year contestable period.[222] Prior to the insured's applying for coverage, his treating physician had told him he might have chronic bronchitis or pneumonia due to chronic coughing; the physician also stated that she wanted the insured to have a chest x-ray but did not explain why.[223] An x-ray taken six days prior to completing the application was positive for a lung tumor.[224] Once again, the doctor did not recall what she told the insured other than she wanted a CT Scan. According to the court, you "can't use the word cancer until you have that definitive diagnosis," and the insured did not receive a definitive diagnosis of cancer until after the application was completed.[225]

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[214] Kennedy v. N. Am. Co. for Life & Health Ins., No. 08-2175-JWL, 2009 WL 1374270, at *7 (D. Kan. May 15, 2009).

[215] *Id.* at *1.

[216] *Id.*

[217] *Id*.

[218] *Id.* at *2.

[219] *Id.* at *6.

[220] *Id.* at *8.

[221] No. 1:CV-08-1535, 2009 WL 37640273 (M.D. Pa. Nov. 9, 2009).

[222] *See supra* note 7.

[223] *Neiman*, 2009 WL 37640273, at *4.

[224] *Id*.

[225] *Id.* at *4-5.

In support of its motion for summary judgment, the insurer argued that the temporal proximity of the insured's application to his medical treatment, diagnostic testing and lung cancer diagnosis established knowledge or bad faith justifying rescission of the insured's life insurance policy.[226] The issue of intent, however, involved an inquiry into the state of mind of the applicant—a particularly difficult task when the applicant is dead.[227]

The court noted that a jury could conclude that the insured knew he had a serious medical condition at the time of application and did not disclose the critical facts, including the chest x-ray only six days prior to application and a CT Scan only eight days prior to the Paramedical Supplement.[228] Although this timing could support an inference that the insured purchased insurance because he was afraid he had lung cancer, there was also evidence he did not knowingly make false statements or act in bad faith.[229] Summary judgment was therefore denied.

Similarly, in *Zell-Brier v. Independent Order of Foresters*,[230] the insured completed a medical application for life insurance and answered "no" to the question whether he had "[i]n the past 10 years, been diagnosed by a licensed medical practitioner or provider as having, or received treatment for: (g) Chronic . . . bleeding . . . [or] (j) Depression . . . ?"[231]After the insured's death, the insurer's investigation resulted in rescission of coverage.[232]

Two physicians stated they had never diagnosed the insured with these conditions.[233] One doctor consulted the insured by phone during which the insured reported he "often" had blood in his stool if he ate badly or ate sugar, that he had some depression in the past two years due to his financial condition and lots of stress.[234] The doctor did not consider these conditions to be a diagnosis or clinically significant.[235]

Rescission was not appropriate because the insured did not misrepresent the facts. A doctor "diagnoses" a patient as having a "condition" based on the individual's signs and symptoms; by contrast, simply considering someone's self-reported symptoms is not a

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[226] *Id.* at *7.

[227] *Id.* at *9.

[228] *Id.* at *8.

[229] *Id*.

[230] No. 6:11-cv-1566-Orl-28TBS, 2012 WL 6089713 (M.D. Fla. Dec. 7, 2012).

[231] *Id.* at *1.

[232] *Id*.

[233] *Id.* at *2-3.

[234] *Id.* at *3.

[235] *Id.* at *4.

"diagnosis."[236] Similarly, "chronic" requires a problem to be of a long duration or frequent recurrence.[237] "Depression" refers to a depression in the sense of a medical disorder.[238] Summary judgment was therefore granted to the beneficiary.[239]

IV.
Conclusion

Rescinding an insurance policy is necessary when the insured fails to honestly disclose requested information on the application. Otherwise, insureds can obtain coverage to which they are not entitled, and the general public suffers through higher premiums. However, rescission is a drastic remedy, denying the insured not only the promised policy benefits but also the policy coverage from the day it was issued. Judges and juries critically review rescission and often punish the insurer for an incorrect decision. Accordingly, it is necessary for the insurer to fully understand the rescission laws of the applicable jurisdiction and to carefully review all the evidence to be certain each required element for rescission is documented.

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[236] *Id.* at *3.

[237] *Id*.

[238] *Id.* at *4.

[239] *Id*.

Coverage Questions Concerning Cybercrimes†

Alan Rutkin
Robert Tugander

I.
Introduction

Insurance coverage law has one firm rule: *When a new risk emerges, new coverage issues follow.*

Cybercrime is a major emerging risk.[1] People use computers in many nefarious ways. Sometimes, the crimes are new and different, such as stealing customer lists, credit card data, or trade secrets. Other times, cybercrimes are new versions of old deeds. Today, bank robbers can use laptops and wifi instead of masks and guns.

In lawyers' eagerness to report on new trends, we sometimes suffer from the "Chicken Little" phenomenon, excitedly addressing concerns that never materialize, such as Y2K. Cybercrime, however, is real.

The headlines make this clear. In August 2014, it was reported that a Russian crime ring stole 1.2 billion usernames and passwords.[2] In 2013, Adobe revealed that hackers stole tens of millions of records.[3] That same year, cyberattacks on retailers such as Target

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† Submitted by the authors on behalf of the FDCC Insurance Coverage Section.

[1] Danny Yadron, *Police Grapple with Cybercrime*, Wall St. J. (Apr. 21, 2014), http://www.wsj.com/articles/SB10001424052702304626304579508212978109316.

[2] Nicole Perlroth & David Gelles, *Russian Hackers Amass Over a Billion Internet Passwords,* N.Y. Times (Aug. 5, 2014), http://www.nytimes.com/2014/08/06/technology/russian-gang-said-to-amass-more-than-a-billion-stolen-internet-credentials.html?_r=0.

[3] *Id*.

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and Michael's compromised account information of millions of customers.[4] More recently, some 56 million credit cards may have been compromised in a five month attack on Home Depot.[5]

Statistics tell the story best. In 2013, there were 62% more data breaches than in 2012.[6] Eight of the breaches exposed more than 10 million identities each.[7] In 2013, over 552 million identities were breached.[8] A new risk—cybercrime—has emerged.

Now, insurance coverage issues are emerging. Several factors complicate this body of coverage law.

First, cybercrimes require courts to fit new technologies into old categories. Is data "physical"? Is a data breach a "publication"? How do "intentional act" exclusions apply to computer activity? Courts are wrestling with these and many related issues.

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[4] Elizabeth A. Harris, *Michaels Stores' Breach Involved 3 Million Customers*, N.Y. Times (Apr. 18, 2014), http://www.nytimes.com/2014/04/19/business/michaels-stores-confirms-breach-involving-three-million-customers.html.

[5] Robin Sidel, *Home Depot's 56 Million Cards Breach Bigger Than Target's*, Wall St. J. (Sept. 18, 2014), http://www.wsj.com/articles/home-depot-breach-bigger-than-targets-1411073571.

[6] Symantec Corp., Internet Security Threat Report 5 (2014), *available at* http://www.symantec.com/content/en/us/enterprise/other_resources/b-istr_main_report_v19_21291018.en-us.pdf.

[7] *Id*.

[8] *Id*.

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Second, cybercrime-related claims (i.e., "cyberclaims") implicate new and different policy forms. During the last two decades of the 20th century, pollution-related damage raised a host of difficult coverage questions. But these questions generally arose under traditional property or CGL policies and focused on a few common policy terms. Cyberclaims, by contrast, often involve new or different policy forms and novel terms.

Third, computer-specific policies involve factually intensive questions. Policies written to provide coverage for computer-related risks provide specific grants of coverage. Coverage is limited to defined persons, acts, and injuries. These limitations lead to factual disputes.

Given these three factors, as well as the complexity inherent in new technology, difficult coverage issues are emerging. At the time of this writing, courts have decided fewer than forty cyberclaim cases. Most of these cases involve one or more of the following five questions:

1. Does the policy apply to acts by this person?
2. Does the policy cover this act?
3. Does the policy bar coverage because of this person's intent?
4. Does the policy cover this type of injury?
5. Does the policy limit coverage to losses caused "directly" by computer activity?

While the body of case law is still too small to identify trends or majority views, these five questions help organize and understand the existing law.

II.
The Coverage Questions

A. *Does the Policy Apply to Acts by This Person?*

A common coverage question in cyberclaims is whether the policy applies to the acts of the *person* who used the computer to cause the injury.

The issue is authorization. Both *authorized* persons and *unauthorized* persons present risks. But the risks are different, and policies treat them differently. Computer-specific policies often limit coverage to the bad acts of persons who are *not* authorized to use the computer. The issue of authorization has led policyholders to litigate many challenges. In nearly all of the reported decisions, however, insurers have won.

Because computer-specific policies typically exclude acts by employees , the authority issue often focuses on employment status. For example, in *Apps Communication, Inc. v. Hartford Casualty Insurance Co.*,[9] a policyholder sued for coverage under a Computers and Media Endorsement. The endorsement covered physical damage to computer equipment but excluded dishonest or criminal acts by employees.[10] A virus damaged the policyholder's computers, deleting, damaging, or disrupting more than 1,000 files on the computer system and generally disrupting the policyholder's business operations.[11] The policyholder alleged that "a computer virus was introduced" into its computer system, but did not allege who or what introduced the virus. In a decision very favorable to insurers, the court dismissed the policyholder's complaint, ruling that the policyholder's use of the passive voice and absence of detail made the complaint deficient as a matter of law. The policyholder needed to allege who introduced the virus to make it clear that the employee exclusion did not apply.[12]

In *NMS Services, Inc. v. Hartford*,[13] the court reached the same result under what appears to be the same policy form. Again, a policyholder made a claim under a Computer and Media Endorsement to a Special Property Coverage Form.[14] The bad actor, while employed by the policyholder, installed malicious software onto the policyholder's computer system that allowed him to hack into the system after he was terminated and destroy computer files and databases necessary for the operation of the policyholder's business.[15] As in *Apps*

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[9] No. 11 C 3994, 2011 WL 4905628 (N.D. Ill. Oct. 14, 2011); *see also Palm Hills Props. v. Continental Ins. Co*., No. 07-668-RET-SCR, 2008 WL 4303817 (M.D. La. July 23, 2008) (applying employee exclusion to bar coverage).

[10] *Apps Communication*, 2011 WL 4905628, at *3.

[11] *Id.* at *1.

[12] *Id*. at *3. It is hornbook law that, in general, insurers have the burden to prove the applicability of an exclusion. The effect of the court's ruling in *Apps Communication* was to place the burden on the policyholder to allege facts sufficient to establish that the exclusion did not apply.

[13] 62 F. App'x 511 (4th Cir. 2003).

[14] *Id*. at 512.

[15] *Id*.

Communication, the court ruled that the Endorsement's dishonesty exclusion precluded coverage for the damage.[16]

But that did not mean the policyholder was deprived of coverage altogether. The Special Property Coverage Form itself contained an identical dishonesty exclusion. That exclusion, however, was subject to an *exception*, not found in the Endorsement, which stated that the exclusion did not apply to "acts of destruction by [the policyholder's] employees."[17] Because it was undisputed that the majority of the wrongdoer's bad acts, including installation of the malicious software that allowed destruction of the computer files, occurred while he was an employee, the exception applied, and the policyholder was entitled to coverage in accordance with the provisions of the Special Property Coverage Form.[18]

In addition to exclusions for employee wrongdoing, policies often exclude acts of "authorized representatives."[19] At least two courts have considered and enforced such exclusions.

In *Stop & Shop Cos. v. Federal Insurance Co.*, the First Circuit applied an "authorized representatives" exclusion when a tax payment service stole $55 million from a supermarket.[20] In *Milwaukee Area Technical College v. Frontier Adjusters*, the court applied an "authorized representatives" exclusion when a college's claim adjuster stole $1.6 million.[21]

Three other courts faced more nuanced versions of the authorized persons issue.

In *Universal American Corp. v. National Union Fire Insurance Co*., a "Computer Systems Fraud" rider to a Financial Institution Bond covered "[l]oss resulting directly from a fraudulent . . . entry of Electronic Data . . . into [the policyholder's] proprietary Computer System."[22] The policyholder, a health insurer, suffered over $18 million in losses from fraudulent claims.[23] Most of these claims were submitted by authorized users (providers) who entered fraudulent claim information. The case hinged on the meaning of "fraudulent entry." Did coverage extend to the entry of fraudulent information by authorized users, or was it limited to instances where the entry into the system itself was fraudulent (i.e., unauthorized)? The court, a New York trial court, could not find any New York precedents. Citing decisions from other states, the court found that "entry" unambiguously focused on the act of entering data:

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[16] *Id.* at 514.

[17] *Id.* at 513.

[18] *Id.* at 513-14.

[19] *See, e.g.,* Stop & Shop Cos. v. Federal Ins. Co., 136 F.3d 71, 72 (1st Cir. 1998) (excluding coverage for loss due to "[t]heft or any other fraudulent, dishonest or criminal act . . . by any [e]mployee, director, trustee or authorized representative of the Insured whether acting alone or in collusion with others").

[20] *Id*. at 72, 76.

[21] 752 N.W.2d 396, 399, 402 (Wis. Ct. App. 2008).

[22] 959 N.Y.S.2d 849, 860 (Sup. Ct. 2013).

[23] *Id*. at 861.

> [T]he Rider states that it covers "fraudulent entry" of data or computer programs into Universal's computer system which resulted in a loss. This indicates that coverage is for an unauthorized entry into the system, i.e. by an unauthorized user, such as a hacker, or for unauthorized data, e.g. a computer virus. Nothing in this clause indicates that coverage was intended where an authorized user utilized the system as intended, i.e. to submit claims, but where the claims themselves were fraudulent.[24]

Because, in the cases before it, the entry of the data was legitimate (even though the data itself was fraudulent), the court found for the insurer.[25]

In *Morgan Stanley Dean Witter & Co. v. Chubb Group of Insurance Cos.*,[26] a New Jersey court faced a similar issue. An authorized person made unauthorized transfers causing about $100 million in losses.[27] Morgan Stanley made claims under an "Electronic and Computer Crime Policy" insuring it "against fraudulent instructions communicated by voice, fax, and computer."[28] The coverage differed depending on the manner by which instructions were given. Where faxes were used, the policy covered only losses from statements that "fraudulently purport to have been made by a customer . . . but which FAX instructions were not made by the customer . . . ."[29] That is, the fax coverage was "imposter coverage," applicable only if the person giving the instruction was not authorized to do so.[30] The voice coverage, however, extended to unauthorized instructions by authorized persons.[31] Consequently, the court found that the fax coverage did not apply, but the voice coverage did apply.[32]

In California, in *Pestmaster Services, Inc. v. Travelers Casualty & Surety Co. of America*, a federal district court found there was no coverage under a policy covering losses resulting from "Computer Crime" for fraud committed by a payroll company.[33] The payroll company, which was authorized to electronically transfer funds from the insured's account into its own as part of its payroll services, failed to pay the insured's payroll taxes as required by the contract, and instead used the money to pay its own obligations.[34] The insured made a claim

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[24] *Id.* at 853.

[25] *Id*. at 864.

[26] No. L-2928-01, 2005 WL 3242234 (N.J. Super. Ct. App. Div. Dec. 2, 2005).

[27] *Id*. at *1-2.

[28] *Id*. at *1.

[29] *Id*. at *3.

[30] *Id.*

[31] *Id*. at *5.

[32] *Id*.

[33] No. CV-13-5039-JFW (MRWx), 2014 WL 3844627, at *6-7 (C.D. Cal. July 17, 2014).

[34] *Id.* at *1, 7.

under its Computer Crime coverage, which covered losses directly caused by "Computer Fraud," defined as the "'use of any computer to fraudulently cause a transfer of Money, Securities, or Other Property from inside the Premises or Banking Premises' to a person or place outside the Premises or Banking Premises."[35] According to the court, "Computer Fraud" thus occurs "when someone 'hacks' or obtains unauthorized access or entry to a computer in order to make an unauthorized transfer or otherwise uses a computer to fraudulently cause a transfer of funds."[36] Because the payroll company's transfer of funds was authorized and did not involve hacking or any unauthorized entry into a computer system, its acts did not constitute "Computer Fraud." [37] Rather, the fraud took place only after the authorized transfer, and there was no coverage.[38]

In a well-publicized case on a related issue, *Zurich American Insurance Co. v. Sony*,[39] the question was whether the "publication" requirement in a commercial general liability policy's Personal and Advertising Injury coverage was limited to publication by the *policyholder* or extended to publication by *anyone*. The incident giving rise to the litigation was widely reported. Purchasers of Sony's PlayStations gave Sony personal identification, including names, addresses, and credit card data. Hackers breached Sony's system and stole the information. Suits followed. Sony then sought coverage under its Personal and Advertising Injury coverage, which covered injury arising out of "oral or written publication, in any manner, of material that violates a person's right of privacy." According to the court, "publication" meant "publication by the policyholder":

> [The policy] provides coverage only in that situation where the [policyholder] . . . commits or perpetrates the act of publicizing the information . . . . [T]here was no act or conduct perpetrated by Sony, but it was done by third party hackers illegally breaking into that security system. And that alone does not fall under [the invasion of privacy] coverage provision.[40]

Thus, there was no coverage. Sony is appealing.

An Indiana federal court held similarly in *Defender Security Co. v. First Mercury Insurance Co.*[41] Although there was no data breach, the case involved whether there was a

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[35] *Id.* at *6

[36] *Id.*

[37] *Id*. at *6-7.

[38] *Id*. at *7.

[39] Hearing Tr., No. 651982/2011 (N.Y. Sup. Ct. Feb. 21, 2014) (filed as order Mar. 4, 2014); s*ee N.Y. Court: Zurich Not Obligated to Defend Sony Units in Data Breach Litigation*, Ins. J. (Mar. 17, 2014), http://www.insurancejournal.com/news/east/2014/03/17/323551.htm.

[40] Hearing Tr. at 80.

[41] No. 1:13-cv-00245-SEB-DKL, 2014 WL 1018056 (S.D. Ind. Mar. 14, 2014).

publication of an individual's personal information.[42] The plaintiff in the underlying lawsuit against the insured, Defender Security, responded to an ad for home security services by calling a toll free number.[43] She shared personal information with Defender, including her name, address, date of birth, and social security number.[44] She was unaware that the call was being recorded.[45] Plaintiff alleged that Defender's use of call recording technology violated California Penal Code section 632.7, which prohibits the recording of confidential communications made by telephone without the consent of all parties.[46] Defender then sought coverage under the Personal and Advertising Injury provisions of its CGL policy, which required that injury arise from "publication of material that violates a person's right of privacy."[47] The court found there was no "publication."[48] The fact that plaintiff shared personal information during her call, the court reasoned, established at most that plaintiff published information about herself, not that the insured published information about her.[49]

In May 2014, the Insurance Services Office, Inc. (ISO) began introducing endorsements that exclude coverage for claims arising from the disclosure of confidential or personal information. The primary endorsement is CG 21 06 05 14, entitled "Exclusion–Access or Disclosure of Confidential or Personal Information and Data-Related Liability."[50] The current CGL form already has an "Electronic Data" exclusion that excludes coverage for "[d]amages arising out of the loss of, loss of use of, damage to, corruption of, inability to access, or inability to manipulate electronic data."[51] The new endorsement supplements the existing exclusion by stating that insurance does not apply to damages arising out of "[a]ny access to or disclosure of any person's or organization's confidential or personal information, including patents, trade secrets, processing methods, customer lists, financial information,

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[42] *Id*. at *3.

[43] *Id*. at *1.

[44] *Id*.

[45] *Id*.

[46] *Id*.

[47] *Id.* at *2.

[48] *Id*. at *4-5.

[49] *Id.* at *4. *But see Encore Receivable Mgmt., Inc. v. Ace Prop. & Cas. Ins. Co.,* No. 1:12-cv-297, 2013 WL 3354571, at *9 (S.D. Ohio July 3, 2013) (concluding that "publication" occurred "at the very moment that the conversation is disseminated or transmitted to the recording device").

[50] Other endorsements include forms CG 21 07 05 14 and CG 21 08 05 14. CG 21 07 05 14 is identical to CG 21 06 05 14 except that it does not include an exception for Bodily Injury. CG 21 08 05 14 is the same with respect to Coverage B, but there is no replacement exclusion under Coverage A for the Electronic Data exclusion. Similar endorsements have also been introduced for commercial umbrella policies.

[51] *E.g.,* ISO form CG 00 01 04 13, Coverage A, Exclusion p; *see ISO Comments on CGL Endorsements for Data Breach Liability Exclusions*, Ins. J. (July 18, 2014), http://www.insurancejournal.com/news/east/2014/07/18/332655.htm [hereinafter *ISO Comments*].

credit card information, health information or any other type of nonpublic information." The exclusion applies to both Coverage A (Bodily Injury and Property Damage) and Coverage B (Personal and Advertising Injury Liability).[52] ISO's explanatory memorandum on the new endorsements states that this is simply a reinforcement of coverage intent—i.e., data breaches and certain data-related liability are not intended to be covered under the CGL form.[53]

B. *Does the Policy Cover This Act?*

In claims arising from cybercrimes, many of the reported cases focus on whether the policy applies to the *act* that caused the injury. The cases address different policy forms with different coverage grants that apply to different factual circumstances. Given the many variables, it is impossible to boil the cases down to a few rules or trends and draw clear lessons. That said, a few points should be noted.

Generally, computer fraud policies cover hacking. Nearly *all* criminals *use* computers. But only *some* criminals *hack* computers. Consequently, a common issue in the "act" cases is distinguishing *hacking* a computer from *using* a computer.

Hacking is "to gain access to a computer illegally."[54] Policyholders have tried to extend hacking coverage to instances in which criminals give bad information that is then legally entered into the policyholder's computer. At least two courts have addressed this scenario. Both courts distinguished giving bad information from actually breaking into a computer, and both courts found that the hacking coverage did not apply.[55]

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[52] The endorsement further provides that the exclusion will apply even if damages are claimed for notification costs, credit monitor expenses, forensic expenses, public relations expenses or any other loss, cost or expense incurred by the named insured or other with respect to that which is subject to the exclusion. This endorsement includes a limited Bodily Injury exception arising out of the loss of, loss of use of, damage to, corruption of, inability to access, or inability to manipulate electronic data. *ISO Comments*.

[53] *Id.*

[54] *Hack Definition*, MerriamWebster.com, http://www.merriam-webster.com/dictionary/hack (last visited Sept. 19, 2014).

[55] Hudson United Bank v. Progressive Cas. Ins. Co., 112 F. App'x 170, 175 (3d Cir. 2004) (loss from fraudulent data entry not covered because data not entered into policyholder's computer); Northside Bank v. Am. Cas. Co., 60 Pa. D. & C. 4th 95, 102 (Ct. C.P. 2001) (coverage protecting bank against hackers did not apply to introduction of information that was fraudulent when received). *See also* Metro Brokers v. Transp. Ins. Co., No. 1:12-cv-3010-ODE, 2013 WL 7117840 (N.D. Ga. Nov. 21, 2013) (policyholder conceded that malicious code and system penetration exclusion applied to virus).

Another issue is that computer fraud policies often require a specific "transfer." Two courts have focused on this issue. In one case, the court did not require a "physical" transfer.[56] In the other, the court found that the transfer must take place from inside the specified premises.[57]

The remaining "act" cases involved fact patterns that seem isolated, if not unique. In one case, a court rejected a policyholder's argument that stealing a computer program could somehow be advertising injury; there was no advertising activity.[58] In three other cases, courts rejected insurers' efforts to apply act-specific exclusions.[59]

C. *Does the Policy Bar Coverage Because of This Person's Intent?*

Closely related to the preceding question about acts is the question of intent. Crime involves bad intent. Thus, the question arises whether intentional act exclusions apply to claims arising from wrongdoing involving computers.[60]

In claims arising from computer crime, courts seem willing to enforce intentional act exclusions.

For example, in *I-Frontier v. Gulf Underwriters Insurance Co.*,[61] an employee stole a manual through use of a computer. The victimized company had coverage for cyberspace activities.[62] The coverage was subject to an exclusion for "any act, error, or omission intentionally committed while knowing it was wrongful."[63] Clearly, the theft was intentional. The court applied the exclusion to bar coverage.[64]

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[56] Vonage Holdings Corp. v. Hartford Fire Ins. Co., No. 11-6187, 2012 WL 1067694, *3 (D.N.J. Mar. 29, 2012).

[57] Brightpoint, Inc. v. Zurich Am. Ins. Co., No. 1:04-CV-2085-SEB-JPG, 2006 WL 693377, *6 (S.D. Ind. Mar. 10, 2006) (fraudulent transfers not covered because transfer did not move property from inside to outside premises).

[58] Am. States Ins. Co. v. Vortherms, 5 S.W.3d 538, 544 (Mo. Ct. App. 1999).

[59] Retail Ventures, Inc., v. Nat'l Union Fire Ins. Co., 691 F.3d 821, 833 (6th Cir. 2012) (trade secret exclusion did not apply to credit card theft); Netscape Comms. Corp. v. Fed. Ins. Co., 343 F. App'x 271, 272 (9th Cir. 2009) (exclusion for "providing" internet access did not apply); Owens, Schine & Nicola, P.C. v. Travelers Cas. & Sur. Co., No. CV095024601, 2010 WL 4226958 (Conn. Super. Ct. Sept. 20, 2010) (counterfeiting exclusion did not apply to email scam).

[60] Many courts have held that "lack of intentionality" is an implicit part of insurance contracts. *See, e.g.*, K&L Homes, Inc. v. Am. Family Mut. Ins. Co., 829 N.W.2d 724, 734 (N.D. 2013).

[61] No. 04-5797, 2005 WL 1353614 (E.D. Pa. June 3, 2005).

[62] *Id*. at *1.

[63] *Id*. at *2.

[64] *Id*. at *3.

Similarly, in *Compaq Computer Corp. v. St. Paul Fire & Marine Insurance Co.*,[65] the policyholder was accused of selling computer drives that were defective.[66] The policy excluded "intentionally wrongful acts."[67] The court held that since the "complaints alleged 'intentional' and 'knowing' conduct . . . the intentional-acts exclusion, as a matter of law, precludes coverage . . . ."[68]

Questions of intent inevitably lead to questions of perspective: From whose perspective is intent considered? This question arose in *Lambrecht & Associates, Inc. v. State Farm Lloyds*.[69] The policy covered "accidental direct physical loss."[70] A hacker disrupted the insured's business.[71] The hacker surely acted intentionally. But whose intent mattered, the hacker's or the policyholder's? The court found that although the hacker intended the injury, the injury was not intended by the policyholder.[72] Because the incident needed to be considered from the policyholder's perspective, the incident was covered.[73]

Also, intentional act exclusions may require substantial evidence. In *Eyeblaster Inc. v. Federal Insurance Co.*,[74] the policyholder was accused of maintaining an internet-based advertising program that disrupted users' computers.[75] The insurer invoked the intentional act exclusion. Certainly, the alleged wrongful conduct seemed inherently intentional. But, the court held, the insurer needed to submit evidence specifically showing that the acts were intentionally wrongful.[76] In the absence of such evidence, the court found for the policyholder and enforced coverage.

D. *Does the Policy Cover This Injury?*

The fourth major dispute concerns whether the policy covers the *injury*. This dispute usually focuses on one of two issues. First, disputes arise whether injuries are "physical" or "tangible" under the policy's Property Damage Liability coverage.[77] Second, disputes

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[65] No. C3-02-2222, 2003 WL 22039551 (Minn. Ct. App. Sept. 2, 2003). This case addressed intent. But unlike most of the other cases addressed in this Article, the case did not involve acts that were nefarious.

[66] *Id*. at *1.

[67] *Id*.

[68] *Id*. at *5.

[69] 119 S.W.3d 16 (Tex. App. 2003).

[70] *Id*. at 18.

[71] *Id*.

[72] *Id*. at 22.

[73] *Id*.

[74] 613 F.3d 797 (8th Cir. 2010).

[75] *Id*. at 799.

[76] *Id*. at 804.

[77] "Property damage" is typically defined as "physical injury to tangible property" or "loss of use of tangible property that is not physically injured."

arise as to whether injuries constitute "Personal Injury" as defined in the policy's Personal and Advertising Injury Liability coverage.

Even though digital data differs from our view of "physical," policyholders have often succeeded in arguing that data is "physical."

Several policyholders established "physical" damage by tying data to hardware. For example, in *Eyeblaster Inc. v. Federal Insurance Co.*, the Eighth Circuit held that a frozen computer constituted a loss of use of tangible property.[78] There, the court focused on the computer itself to find something physical.[79]

Similarly, in *Vonage Holdings Corp. v. Hartford Fire Insurance Co.*,[80] the court found a loss to be insured by focusing on the lost ability to use full capacity of servers.

Finally, in *Lambrecht v. State Farm*,[81] the court again focused on hardware to find something "physical." The insurer argued that loss of information was not "physical" because it did not exist in a physical form. The court, however, found that the loss was "physical" because it affected the server, which had a hard drive that could not be used.[82]

In *Landmark American Insurance Co. v. Gulf Coast Analytical Laboratories*,[83] the court did not focus on the hardware; it focused purely on the data. This focus should have favored the insurer, but the policyholder still won. The *Landmark* court held that:

> [T]angibility is not a defining quality of physicality according to Louisiana law. The Louisiana Supreme Court determined that though electronic data is not tangible it is still physical because it can be observed and altered [through] human action. Therefore, according to Louisiana law, GCAL's electronic chemical analysis data must be considered a corporeal movable or physical in nature. Therefore . . . GCAL's electronic data "has physical existence, takes up space on the tape, disc, or hard drive, makes physical things happen, and *can be perceived by the senses*." Since

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78 613 F.3d at 802.

79 *Id*.

80 2012 WL 1067694, at *3.

81 119 S.W.3d 16 (Tex. App. 2003).

82 *Id*. at 23. Outside of the crime context, courts have reached different conclusions about whether data is tangible. For example, in *America Online, Inc. v. St. Paul Mercury Ins. Co.,* 347 F.3d 89, 95 (4th Cir. 2003), the court held that lost data is not "physical damage to tangible property." But, the court held, "if a hard drive were physically scarred or scratched so that it could no longer properly record data . . . then the damage would be physical . . . ." On the other hand, another court found that "'physical damage' is not restricted to the physical destruction or harm of computer circuitry but includes loss of access, loss of use, and loss of functionality." Am. Guar. & Liab. Ins. Co. v. Ingram Micro, Inc., No. 99-185 TUC AM, 2000 WL 726789, at *2 (D. Ariz. Apr. 18, 2000).

83 No. 10-809, 2012 WL 1094761 (M.D. La. Mar. 30, 2012).

> the GCAL's electronic data is physical in nature under Louisiana law, summary judgment is appropriate, declaring that electronic data is susceptible to "direct, physical 'loss or damage.'"[84]

It seems unlikely that the *Landmark* court's analysis will gain broad acceptance. First, the case was decided under Louisiana's civil law conception of "corporeal movable property," which the court itself noted differed from the common law interpretation.[85] Second, the court's analysis simply does not withstand scrutiny. While it was appropriate for the court to consider physicality as being "perceived by the senses"—in fact, "physical" is defined as "existing in a form that you can touch or see"[86]—you cannot "touch or see" digital data.

In fact, in a case on a related issue, *Carlon Co. v. DelaGet*, LLC,[87] the court found for the insurer. The policyholder was sued for negligence in safeguarding a bank passcode, which allowed money to be removed from a customer's bank account. The court held there was no property damage coverage because electronic bank account funds were not "tangible property."[88]

The question whether computer crimes constitutes "Personal Injury" within the meaning of Personal and Advertising Injury Liability coverage has also been the source of litigation. Here, insurers and policyholders have both enjoyed victories, leaving no clear law.

With respect to the invasion of privacy offense—e.g., "oral or written publication, in any manner, of material that violates a person's right of privacy"—a key question is whether a "publication" has occurred. In the computer crime context, this question is complicated. Is there "publication" once the thief acquires the information, or does "publication" require something more? Again, courts disagree. At least one court has found that the acquiring of information is not in itself a publication.[89] But another court, interpreting a policy that required "making known" the information (as opposed to "publication"), the court held that intercepting and internally disseminating messages is "making known" the information.[90] In so holding, the court found the policy's language covering disclosure to "any" person or organization to be dispositive.

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[84] *Id.* at *4 (emphasis added).

[85] "The Louisiana Civil Code departed from the narrow Roman law conception that only 'tangible objects' were corporeal; instead, 'the Louisiana Civil Code of 1870 declared that perceptibility by any of the senses sufficed for the classification of a material thing as corporeal.'" *Id.* at *3.

[86] *Physical Definition*, Merriam-Webster.com, http://www.merriam-webster.com/dictionary/physical (last visited Sept. 19, 2014).

[87] No. 11-CV-477-JPS, 2012 WL 1854146 (W.D. Wis. May 21, 2012).

[88] *Id*. at *4.

[89] Recall Total Info. Mgmt., Inc. v. Fed. Ins. Co., 83 A.3d 664, 672-73 (Conn. App. Ct. 2014).

[90] Netscape Comms. Corp. v. Fed. Ins. Co., 343 F. App'x 271, 272 (9th Cir. 2009).

Beyond the cases concerning the definition of "physical" and the scope of "Personal Injury" coverage, several cases address the characterization of the insured's loss. In *Retail Ventures, Inc. v. National Union Fire*, the Sixth Circuit rejected an insurer's effort to treat credit card information as "trade secrets," and thus held a trade secrets exclusion did not apply.[91] In *Royal American Group v. ITT Hartford*, the court rejected a policyholder's attempt to characterize distance telephone services as "securities," and thus held these services were not "covered property" (a term defined to include "securities").[92]

E. *Does the Policy Limit Coverage to Losses Caused "Directly" by Computer Activity?*

Claims under computer policies typically limit coverage to "direct losses" from, or "loss resulting directly from," specified computer-related misconduct. Thus, these claims frequently raise causation issues.

Insurers often argue that "direct means direct."[93] At a minimum, insurers maintain that direct means immediate, without an intervening cause. Policyholders, on the other hand, argue for a "proximate cause" approach.

In *Owens, Schine & Nicola, P.C. v. Travelers Casualty & Surety Co.*[94] and *Retail Ventures, Inc. v. National Union Fire Insurance Co.*,[95] criminals used computers to gain access to their victims. In *Owens*, the criminal solicited the victim by email, and then once in contact, defrauded the victim. In *Retail Ventures*, the criminals used computers to steal credit card information, and then stole from the accounts. In other words, the computers were used to set up the crimes, but the computers were not used to effectuate the crimes. Both courts found the losses resulted directly from computers.

On the other hand, several courts have found that the use of a computer was merely incidental to the loss and thus not covered. In *Pinnacle Processing Group v. Hartford Casualty Insurance Co.*,[96] the court held that "direct" means "without any intervening cause." In *Brightpoint, Inc. v. Zurich American Insurance Co.*,[97] the court cited *Black's Law Dictionary* to state that direct means "[i]n a straight line or course" and "immediately."[98] In *Pestmaster*,

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91 691 F.3d 821, 833 (6th Cir. 2012).

92 No. 16246, 1994 WL 14888, *2-3 (Ohio Ct. App. Jan. 12, 1994).

93 *See, e.g.,* Retail Ventures, Inc. v. Nat'l Union Fire Ins. Co., 691 F.3d 821, 828-29 (6th Cir. 2012) (collecting cases).

94 No. CV095024601, 2010 WL 4226958 (Conn. Super. Ct. Sept. 20, 2010).

95 691 F.3d 821.

96 No. C10-1126-RSM, 2011 WL 5299557, at *5. (W.D. Wa. Nov. 4, 2011).

97 No. 1:04-CV-2084-SEB.-JPG, 2006 WL 693377 (S.D. Ind. Mar. 10, 2006).

98 *Id.* at *7.

the court stated, "direct means direct," and held that losses must "flow immediately and directly" from computer use.[99]

In *Metro Brokers, Inc. v. Transportation Insurance Co.*, the court took a broader view of causation based on policy language excluding loss "caused directly or indirectly" by "malicious [computer] code" or "system penetration."[100] Thieves used a computer virus to steal a bank customer's login and password information, then accessed the bank's online banking system and transferred money from the customer's accounts to other accounts in the thieves' control.[101] A dispute arose as to whether the policy's virus exclusion applied.[102] The policyholder argued that the exclusion did not apply because the virus was not the "cause" of the loss; rather, the loss was caused by the actions of humans using information obtained by the virus.[103] Because the exclusion applied to any loss "caused directly *or indirectly*" by a virus, the causation requirement was relaxed.[104] Moreover, the exclusion applied "regardless of any other cause or event that contributes concurrently or in any sequence to the loss."[105] Thus, the court ruled, "[t]he virus's contribution to this particular loss is not too remote to fall outside the parameters of proximate causation contemplated" by the policy.

Insurers won two other causation cases, but both cases show that computer fraud coverage requires more than a criminal using a computer; the criminal must use the computer to cause the fraud. In *Great American Insurance Co. v. AFS/IBEX Financial Services, Inc.,*[106] an insurance agent used a computer to file false insurance premium financing applications with AFS/IBEX, which then sent send premium checks to the agent, who deposited them in his own account. According to the court, the loss was not covered because it did not "directly stem[] from fraud perpetrated by use of a computer," as required by the policy.[107]

In *Methodist Health System Foundation, Inc. v. Hartford Fire Insurance Co.*,[108] the insured invested in a mutual fund that invested in a hedge fund that in turn invested with Bernard Madoff. The insured suffered losses from its investment portfolio after Madoff's Ponzi scheme was discovered and sought coverage for these losses under a commercial crime

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[99] *Pestmaster Servs., Inc. v. Travelers Cas. & Sur. Co.,* No. CV-13-5039-JFW (MRWx), 2014 WL 3844627, at *7 (C.D. Cal. July 17, 2014) (computer was merely incidental to misuse of funds where fraud occurred after an authorized electronic transfer).

[100] No. 1:12-CV-3010-ODE, 2013 WL 7117840, at *1 (N.D. Ga. Nov. 21, 2013).

[101] *Id*. at *2.

[102] *Id*. at *2-3.

[103] *Id*. at *2.

[104] *Id.* at *5 (emphasis added).

[105] *Pestmaster*, 2014 WL 3844627, at *5.

[106] No. 3:07-CV-924-O, 2008 WL 2795205 (N.D. Tex. July 21, 2008).

[107] *Id.* at 14.

[108] 834 F. Supp. 2d 493 (E.D. La. 2011).

policy. The court rejected this claim: "[W]hile the Madoff ponzi scheme was a contributing factor in Plaintiff's sustained losses, [it] was not a direct cause of Plaintiff's losses" as required by the policy.[109] The loss was "too many steps removed from Madoff's fraud"[110] and thus was not covered.

Much like causation cases in the tort context, the causation cases here are difficult to reconcile. Four courts have addressed this issue, with insurers winning two and policyholders winning two. Moreover, insurers won the two cases with the tighter causal chain; courts found the chain too attenuated to establish causation. Policyholders won the two cases with the weaker causal chain; courts found the chain adequate to establish causation.

One possible explanation is that "proximate cause" is a relaxed standard. Three of the courts that found for policyholders adopted the "proximate cause" approach.[111] Nonetheless, it is unclear that "proximate cause" means something different from the terms that courts used in finding for insurers.

III.
Conclusion

Since fewer than forty courts have addressed insurance coverage for criminal conduct, it is too soon to draw firm conclusions. But the five issues discussed here seem likely to recur.

The coverage disputes may extend to other issues. In fact, the cases concerning cybercrime do address a few other issues. Some of these issues are specific to computers.[112]

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[109] *Id.* at 496.

[110] *Id*. at 497.

[111] *See* Owens, Schine & Nicola, P.C. v. Travelers Cas. & Sur. Co., No. CV095024601, 2010 WL 4226958 (Conn. Super. Ct. Sept. 20, 2010); Retail Ventures, Inc., v. Nat'l Union Fire Ins. Co., 691 F.3d 821, 831-32 (6th Cir. 2012)*;* Transtar Elec., Inc. v. Charter Oak Fire Ins. Co., No. 3:13cv1837, 2014 WL 252023, at *4 (N.D. Ohio Jan. 22, 2014).

[112] *See, e.g.,* I-Frontier, Inc. v. Gulf Underwriters Ins. Co., No. 04-5797, 2005 WL 1353614, at *3 (E.D. Pa. June 3, 2005) (declining to "delve into the interpretation of the term 'cyber-space activities'"); Eyeblaster Inc. v. Fed. Ins. Co., 613 F.3d 797 (addressing application of intellectual property exclusion); Nationwide Ins. Co. v. Hentz, No. 11-cv-618-JPG-PMF, 2012 WL 734193, at *6 (S.D. Ill. Mar. 6, 2012) (addressing application of care and custody exclusion to stolen laptop); Hewlett-Packard Co. v. Factory Mut. Ins. Co., No. 04 Civ. 2791 (TPG)(DCF), 2007 WL 983990, at *2-3 (S.D.N.Y. Mar. 30, 2007) (excusing insured's late notice of claim based on delayed discovery of computer sabotage).

Other coverage cases involving cybercrime seem to hinge on insurance issues that are not computer-centric.[113]

Ultimately, since these claims are brought under specifically tailored policy provisions, these factually intensive coverage disputes will continue to arise.

[113] Freedom Banc Mortg. Servs., Inc. v. Cincinnati Ins. Co., No. 13AP-400, 2014 WL 294655, at *1 (Ohio Ct. App. Jan. 23, 2014) (analyzing time limit on suit); Pollak v. Fed. Ins. Co., No. 13-12114-FDS, 2013 WL 6152335, at *4 (D. Mass. Nov. 21, 2013) (interpreting "intended beneficiary"); Saint Consulting Grp., Inc. v. Endurance Am. Specialty Ins. Co., No. 11-11279-GAO, 2012 WL 1098429, at *3 (D. Mass. Mar. 30, 2012) (addressing application of exclusion for statutory violations).

Are You as Guilty as the Criminal? Liability for Criminal Acts of Third Parties and Employees†

Sean W. Martin
Reed Bates
Michael McMyne

I. Introduction

Violent criminal activity in and around bars, restaurants, hotels, retail shops, and healthcare facilities is unfortunately an all-too-common occurrence. When customers of these businesses are victimized by criminal actors, the injuries and damages sustained are often horrific and shocking, and expose the business to almost certain litigation. These cases present special difficulties for the owner of the business or premises: Even though the

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owner's potential liability is typically secondary to that of the criminal, the owner is likely the only source of available funds in the event of an adverse judgment. This can result in a guilt-by-association mindset as the jury tries to compensate the victim of a terrible crime through the deep pockets of a secondary party. To minimize this exposure, then, business owners must understand the general legal principles governing such cases, the types of cases in which liability is likely to be established, and the common insurance issues arising out of such cases. This Article addresses each of these critical issues.

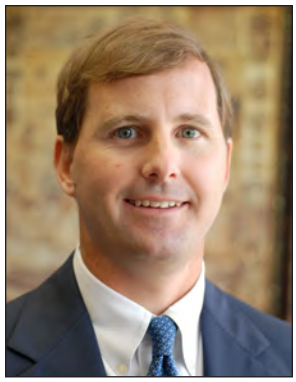
II.
The Law

Courts throughout the country uniformly hold that a business owner is not liable for injuries to others resulting from the criminal acts of third parties unless (1) the criminal act is *foreseeable* and (2) *reasonable efforts can be made* to prevent the criminal conduct from injuring customers. However, despite the overwhelming acceptance of these legal principles, there remains considerable debate over what actions or events give rise to a business owner's duty of care and what reasonable steps must be taken to deter criminals from victimizing those who may be on the premises.

A. *Duty*

There is generally no duty to protect customers from criminal activities of third persons.[1] However, when a criminal act is "reasonably foreseeable," the business owner owes a duty

[1] *See*, *e.g.*, Posecai v. Wal-Mart Stores, Inc., 752 So. 2d 762, 766 (La. 1999). *See also* Sturbridge Partners, Ltd. v. Walker, 482 S.E.2d 339 (Ga. 1997).



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of care toward its customers;[2] indeed, "[t]he touchstone for the creation of a duty is foreseeability."[3] Conversely, absent foreseeability, the business owner owes no duty to protect its customers from criminal conduct.[4] It is the plaintiff's burden to prove the foreseeability of the criminal act that caused his or her injuries.[5]

In addition to the duty owed by a business owner in the event of foreseeable criminal conduct, a business owner may have a duty to intervene to protect its customers during the commission of a crime. This may involve expelling the criminal actor from the premises or calling 911.[6]

The owner's duty to intervene may not stop at the front door. Ejecting a patron or calling 911 may not always be enough to meet a business owner's duty. This is especially the case when alcohol is involved, or when there is an altercation between guests. The key question is whether the conduct puts the business on notice that an incident may occur beyond its

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[2] *Posecai*, 752 So. 2d at 766.

[3] Madden v. C & K Barbecue Carryout, Inc., 758 S.W.2d 59, 62 (Mo. 1988).

[4] *See* Burnett v. Stagner Hotel Courts, Inc., 821 F. Supp. 678, 682 (N.D. Ga. 1993).

[5] *See id.*

[6] *See, e.g.*, Saatzer v. Smith, 176 Cal. Rptr. 68 (Ct. App. 1981) (court upheld bar's motion for summary judgment when manager and employees acted to break up bar fight within seconds of its occurrence); Alvarez v. Jacmar Pac. Pizza Corp., 122 Cal. Rptr. 2d 890 (Ct. App. 2002) (restaurant met duty to protect patron when employee called 911 when argument was escalating, even though a subsequent shooting took place when one of the parties returned to the premises after initially leaving).

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doors.[7] On the other hand, if the trouble arises quickly, so the establishment does not have an opportunity to intervene, its failure to do so is not actionable.[8]

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[7] *See*, *e.g.*, Perez v. KFC Nat'l Mgmt. Co., Inc., 454 N.W.2d 145 (Mich. Ct. App. 1990) (restaurant had no duty to protect customer from a second irate customer when attack occurred in parking lot, and there was no evidence of tension between the two customers before exiting the restaurant); Osborne v. Stages Music Hall, Inc., 726 N.E.2d 728 (Ill. Ct. App. 2000) (nightclub may be liable when bouncers ejected fighting men to the sidewalk and then ignored them, while allowing two female patrons to exit the building directly into their path); Fast Eddies v. Hall, 688 N.E.2d 1270 (Ind. Ct. App. 1997) (sexual assault and murder after leaving bar was not foreseeable, even though manager asked one of two men to drive the intoxicated woman home from the bar. Earlier sexual advances in the bar did not put the establishment on notice of the assailant's propensity to commit rape or murder); Delgado v. Trax Bar & Grill, 30 Cal. Rptr. 3d 145 (2005) (bar had duty to protect patron beyond its doors, after several men stared hostilely at the plaintiff for 60 to 90 minutes before bar security asked patron to leave for his own safety, patron was subsequently attacked by multiple parties in the parking lot).

[8] *See*, *e.g.*, Yarborough v. Erway, 705 S.W.2d 198, 203 (Tex. Ct. App. 1985) (nightclub could not have reasonably done anything to prevent harm when fight occurred suddenly); *compare* Eastep v. Jack-In-The-Box, Inc., 546 S.W.2d 116, 118 (Tex. Civ. App. 1977) (restaurant should have intervened in a fight, when two minutes passed before the fighting began, two to five minutes of fighting occurred before the victim was stabbed, and three to five minutes passed after that before the police arrived).

B. *Foreseeability*

Historically, courts held that a criminal act broke the chain of causation so that a premises owner was not liable for injuries caused by the criminal act of another. This often left the victim of the crime unable to recover compensation for such injuries. Over time, courts began to depart from this approach and opted for an analysis of whether the criminal conduct was reasonably foreseeable to the business owner. The result has been a shift from the State being solely responsible for protecting its citizens from harmful criminal conduct to business owners having that responsibility in an increasing number of situations.

The "foreseeability" principle derives from Section 344 of the Restatement (Second) of Torts, which imposes upon a business owner the duty to take reasonable action to protect its invitees against foreseeable, intentional, or criminal acts.[9] Courts, however, have not agreed on the meaning of foreseeability in this context,[10] and "[f]our basic approaches . . . have emerged amongst jurisdictions nationally": the *balancing* test, the *imminent harm* rule, the *prior similar incidents* test, and the *totality of the circumstances* approach.[11] Most courts employ either the "prior or similar incidents" test or the "totality of circumstances" test in deciding whether a criminal act was sufficiently foreseeable to impose a duty on the business owner.[12]

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[9] Restatement (Second) of Torts § 344 (1965); *see* Bass v. Gopal, Inc., 716 S.E.2d 910, 913 (S.C. 2011); Taco Bell, Inc. v. Lannon, 744 P.2d 43, 47 (Colo. 1987); McClung v. Delta Square Ltd. P'ship, 937 S.W.2d 891, 898 (Tenn. 1996); Erichsen v. No-Frills Supermarkets, 518 N.W.2d 116, 118-19 (Neb. 1994); Mundy v. Dept. of Health & Human Res., 620 So. 2d 811, 813-14 (La. 1993); Cotterhill v. Bafile, 865 P.2d 120, 122-23 (Ariz. Ct. App. 1993); Jardel Co., Inc. v. Hughes, 523 A.2d 518, 525 (Del. 1987); Martinko v. H–N–W Assocs., 393 N.W.2d 320, 321-22 (Iowa 1986); Butler v. Acme Markets, Inc., 445 A.2d 1141, 1145-46 (N.J. 1982); Foster v. Winston-Salem Joint Venture, 281 S.E.2d 36, 38-39 (1981); Nallan v. Helmsley–Spear, Inc., 429 N.Y.S.2d 606, 612-14 (N.Y. 1980); Uihlein v. Albertson's, Inc., 580 P.2d 1014, 1018 (Or. 1978). *See also* Donnell v. Spring Sports, Inc., 920 S.W.2d 378, 383 (Tex. Civ. App. 1996) (duty imposed when third-party criminal conduct is a foreseeable result of premise owner's negligence); Seibert v. Vic Regnier Builders, Inc., 856 P.2d 1332, 1338 (Kan. 1993) (duty to protect patrons exists when business "could reasonably foresee that its customers have a risk of peril above and beyond the ordinary and that appropriate security means should be taken."); Shell Oil Co. v. Diehl, 422 S.E.2d 63, 64 (Ga. Ct. App. 1992) ("The proprietor of a business has a duty, when he can reasonably apprehend danger to a customer from the misconduct of [others] to exercise ordinary care to protect the customer . . . ."); Lucht v. Stage 2, Inc., 606 N.E.2d 750, 754 (Ill. App. Ct. 1992) (businesses owe customers duty "to reasonably guard against acts of third parties when such attacks are reasonably foreseeable"); Erickson v. Curtis Inv. Co., 447 N.W.2d 165, 168-69 (Minn.1989) (duty to protect patrons depends, in part, on foreseeability of risk involved); Bullard v. Ehrhardt, 324 S.E.2d 61, 62 (S.C. 1984) ("duty of a store owner to its invitees is to take reasonable care to protect them. This duty does not extend to protection from criminal attacks from third parties unless the store owner knew or had reason to know of the criminal attack.").

[10] *See* McClung v. Delta Square Ltd. Partnership, 937 S.W.2d at 899.

[11] *Bass v. Gopal, Inc.*, 716 S.E.2d at 913-14.

[12] *Id*.

1. Balancing Test

The balancing test weighs the foreseeability and the gravity of the harm to the potential victim against the burden on the business to protect against that harm.[13] This approach recognizes that a business is not the insurer of the safety of its customers, but that, in certain circumstances, it may be required to take reasonable steps to protect its customers from foreseeable harm.[14] "[A] risk is unreasonable and gives rise to a duty to act with due care if the foreseeable probability and gravity of harm posed by the [harmful] conduct outweigh the burden upon the defendant to engage in alternative conduct that would have prevented the harm."[15] This balancing approach takes into account both the economic concerns of the business and the safety concerns of its customers.[16]

2. Imminent/Specific Harm Test

Under the specific harm test, which has been described as "somewhat outdated," "a landowner does not owe a duty to protect patrons from the violent harm of third parties unless he is aware of specific, imminent harm about to befall them."[17]

Under this test, "foreseeability, and thus liability, is limited to situations where the business owner is aware of the imminent probability of specific harm to its customer."[18] According to the New Jersey Supreme Court in *Clohesy v. Food Circus Supermarkets, Inc*.,[19] proving foreseeability under this test becomes difficult because the plaintiff must show that the merchant knew or had reason to know that the third party was committing the crime or about to do so. As a result, courts generally agree that "this rule is too restrictive in limiting the duty of protections that business owners owe their invitees."[20]

3. Prior Similar Incidents Test

Under the prior similar incidents test, foreseeability is established by evidence of previous crimes on or near the premises.[21] The underlying rationale for this test is that a

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[13] *McClung*, 937 S.W.2d at 901.

[14] *Id*. at 902.

[15] *Id.* (quoting *McCall v. Wilder*, 913 S.W.2d 150, 153 (Tenn. 1995)).

[16] Sarah Stephens McNeal, *Torts–Premises Liability–Liability of Tennessee Business Owners for Third-Party Criminal Attacks*, 68 Tenn. L. Rev. 141, 154 (2000).

[17] *Posecai*, 752 So. 2d at 766-767.

[18] Boren v. Worthen Nat'l Bank of Ark., 921 S.W.2d 934, 940-41 (Ark. 1996) (concluding that plaintiff could not establish foreseeability under the imminent harm and prior similar incidents tests, and expressly rejecting the totality of circumstances test).

[19] 694 A.2d 1017 (N.J. 1997).

[20] *Posecai*, 752 So. 2d at 767.

[21] Timberwalk Apts., Partners, Inc. v. Cain, 972 S.W.2d 749, 756-57 (Tex. 1998); Sturbridge Partners, Ltd., v. Walker, 482 S.E.2d 339, 341 (Ga. 1997); Polomie v. Golub Corp., 640 N.Y.S.2d 700, 701 (N.Y. App. Div. 1996).

past history of criminal conduct provides notice to the business owner of the risk of future criminal actions; thus, if similar crimes have occurred on or near the property in question, the business owner should take reasonable steps to protect against their recurrence.[22]

States that apply the prior similar incidents test require the plaintiff to prove foreseeability by evidence that the defendant had actual knowledge of prior "substantially similar" criminal acts on its property.[23] These cases often turn on what constitutes a "substantially similar" crime. Generally, crimes against property, such as breaking into cars in a parking lot, will not be considered "substantially similar" to violent crimes like rape or murder. Moreover, crimes that occur off-premises in the surrounding neighborhood generally do not provide sufficient evidence or notice of similar crimes.[24] Courts also differ as to whether nonviolent crimes committed on the premises adequately put a landowner on notice of the potential for later, violent crimes.

4. Totality of Circumstances Test

The majority of jurisdictions have adopted the totality of the circumstances approach.[25] This more expansive theory was adopted as a reaction to the shortcomings of the "prior

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[22] Courts consider the nature and extent of the previous crimes, as well as their recurrence, frequency, and similarity to the crime in question. "When the general danger is the risk of injury from criminal activity, the evidence must reveal specific previous crimes on or near the premises in order to establish foreseeability." *Timberwalk Apts., Partners, Inc.*, 972 S.W.2d at 756; *accord* Gibbs v. ShuttleKing, Inc., 162 S.W.3d 603, 610 (Tex. Ct. App. 2005).

[23] Carlock v. Kmart Corp., 489 S.E.2d 99 (Ga. Ct. App. 1997); Whitmore v. First Fed. Sav. Bank of Brunswick, 484 S.E.2d 708 (Ga. Ct. App. 1997); Ritz Carlton Hotel Co. v. Revel, 454 S.E.2d 183 (Ga. Ct. App. 1995).

[24] *Cain*, 972 S.W.2d at 758 (rape of a tenant in her apartment was not foreseeable to landlord where no violent personal crimes occurred at apartment complex in previous ten years, one sexual assault occurred within one-mile radius the previous year, and six assaults that occurred in neighboring apartment complexes were neither publicized nor otherwise brought to landlord's attention); Petrauskas v. Wexenthaller Realty Mgmt., Inc., 542 N.E.2d 902 (Ill. App. 1989) (allegations that building was in high-crime area and that person was fatally shot across the street did not render attack reasonably foreseeable); Ann M. v. Pac. Plaza Shopping Ctr., 25 Cal. Rptr. 2d 137 (1993) (knowledge that transients congregated at shopping center and that violent crimes occurred in the census tract in which center was located were insufficient to place shopping center on notice that rape would occur on the premises); Rozhik v. 1600 Ocean Parkway Assocs., 617 N.Y.S.2d 535 (N.Y. App. Div. 1994) (prior incidents of criminal activity in neighborhood surrounding building insufficient); *Buckeridge*, 774 N.Y.S.2d 132 (App. Div. 2004) (several robberies of a grocery store next-door to premises insufficient). But there are exceptions. *See, e.g., Holiday Inns, Inc.*, 576 So. 2d at 331 (foreseeability is determined in light of all circumstances of the case rather than by a rigid application of the mechanical rule requiring evidence of prior similar criminal acts against invitees on the property); Paterson v. Deeb, 472 So. 2d 1210 (Fla. Dist. Ct. App. 1985) (evidence of crimes committed in the surrounding neighborhood was relevant to the question of the foreseeability of an assailant's rape of a tenant at an apartment complex).

[25] Bass v. Gopal, Inc., 716 S.E.2d 910, 914 (S.C. 2011).

similar incidents" approach.[26] According to some courts, this test provides a "better reasoned basis [than the 'prior similar incidents' rule] for determining foreseeability."[27]

The totality of the circumstances approach provides greater latitude to the fact finder in determining when criminal acts of third persons are foreseeable. All relevant factual circumstances—including the nature, condition, and location of the property, as well as any other relevant factual circumstance bearing on foreseeability—may be considered.[28] Moreover, "the lack of prior similar incidents will not preclude a claim where the landowner knew or should have known the criminal act was foreseeable."[29]

Under this test, a plaintiff may introduce evidence of foreseeability that normally would not be allowed in a "prior similar incidents" jurisdiction. This evidence may include the architectural design of the landowner's premises; security measures undertaken by the landowner, such as surveillance cameras, security guards, or enhanced lighting; the character of the business; the character of neighborhood; and all prior crimes, violent and nonviolent, on or near the premises.[30] As a result, courts that use the "totality of the circumstances" test

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[26] *See* Isaacs v. Huntington Mem'l Hosp., 211 Cal. Rptr. 356, 362 (1985) (holding that foreseeability should not be determined by the "rigid application of a mechanical 'prior similars' rule" but, rather, by the totality of the circumstances, which included the location of the property in a high-crime area, criminal assaults on or near the premises, and poor lighting in the parking lot where the assault occurred); *cf.* Ann M. v. Pac. Plaza Shopping Ctr., 25 Cal. Rptr. 2d 137, 145 (1993) (revisiting the "totality of the circumstances" rule and announcing new factors); Seibert v. Vic Regnier Builders, Inc., 856 P.2d 1332, 1339-40 (Kan. 1993) (adopting the "totality of circumstances" approach when the plaintiff was shot in an underground parking garage and no evidence was offered of prior similar crimes in the parking garage); Clohesy v. Food Circus Supermarkets, Inc., 694 A.2d 1017, 1027 (N.J. 1997) (rejecting the "prior similar incidents" rule in favor of the "totality of circumstances" rule); Reitz v. May Co. Dep't Stores, 583 N.E.2d 1071, 1074 (Ohio Ct. App. 1990) (adopting the "totality of circumstances" test, which allowed consideration of evidence of prior nonviolent crimes when the plaintiff was stabbed in a parking lot); Torres v. U.S. Nat'l Bank, 670 P.2d 230, 235-36 (Or. Ct. App. 1983) (describing the "totality of circumstances" test without labeling it). Under the "totality of the circumstances" approach, evidence of prior similar crimes is still an important factor in determining foreseeability. As the California Supreme Court noted, "the requisite degree of foreseeability rarely, if ever, can be proven in the absence of prior similar incidents of violent crime on the landowner's premises." *Ann M.*, 25 Cal. Rptr. 2d at 215.

[27] *Seibert*, 856 P.2d at 1340.

[28] Delta Tau Delta v. Johnson, 712 N.E.2d 968 (Ind. 1999); Clohesy v. Food Circus Supermkts., 694 A.2d 1017 (N.J. 1997); *Seibert*, 856 P.2d at 1339-40.

[29] *Delta Tau Delta*, 712 N.E.2d at 973.

[30] *Clohesy*, 694 A.2d at 1021 (court considered evidence that the store permitted parking in an area impossible to observe from inside the store, as sufficient to present the jury the question of the store's negligence); *Isaacs*, 211 Cal. Rptr. at 359 (noting evidence of an insufficient number of guards and cameras; also noting hospital emergency rooms, surrounding areas, and nearby parking lots had high potential for violent acts); *Seibert*, 856 P.2d at 1340 (remanding to determine what role insufficient lighting played in a shooting); *Clohesy*, 694 A.2d at 1021 (noting evidence that a neighboring gas station and liquor store, which were gathering places for loiterers, should have alerted the grocery store of need for parking lot security and noting evidence of all prior crimes on or near the store's premises for the preceding two-and-one-half years, including shoplifting and driving while intoxicated, and noting the increasing number of offenses).

significantly expands the range of circumstances that might constitute sufficient notice to a business owner of the need to take measures to protect its customers. For example, violent incidents occurring *near* the premises might be sufficient in themselves to put the defendant on notice that crime could occur *on* the premises.

C. *Breach of Duty*

After establishing foreseeability, and thus a duty on the part of the business owner, the plaintiff must prove that the business owner breached that duty. This will almost always be a jury question. To prove breach, a plaintiff should have expert testimony on the reasonable standard of care required, as well as how the defendant's conduct fell below that standard. In general, to succeed, the plaintiff must proffer evidence showing that reasonable security measures would have prevented the criminal conduct that caused plaintiff's injuries.[31]

D. *Causation*

Even assuming the defendant owed and breached a duty of care to the plaintiff, the plaintiff cannot prevail without also proving the breach was the proximate cause of his or her injuries.[32] As is true generally, the plaintiff's evidence of causation, including testimony of causation experts, cannot be based upon speculation and conjecture.[33]

Some courts have noted that proximate cause requires proof of two elements: foreseeability and cause-in-fact.[34] As to the latter element, "if it is shown that the injury would have resulted even though the defendant did that which the plaintiff contends should have been done, then the purported negligence is not a cause-in-fact of the injury."[35]

Section 448 of the Restatement (Second) of Torts is instructive on this issue:

> The act of a third person in committing an intentional tort or crime is a superseding cause of harm to another resulting therefrom, although the actor's negligent conduct created a situation which afforded an opportunity to the third person to commit

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[31] *See generally* Lau's Corp, Inc. v. Haskins, 405 S.E.2d 474 (Ga. 199); Ritz Carlton Hotel Co. v. Revel, 454 S.E.2d 183 (Ga. Ct. App. 1995); Grandma's Biscuits, Inc. v Baisden, 386 S.E.2d 415 (Ga. Ct. App. 1989).

[32] *See* Saelzler v. Advanced Group 400, 107 Cal. Rptr. 2d 617, 623-24 (2001) (affirming summary judgment based on plaintiff's failure to adequately demonstrate defendant's negligence was the proximate cause of her injuries in a case where plaintiff was beaten and sexually assaulted while attempting to deliver a package to an apartment owned by defendant); Nola M. v. Univ. of S. Cal., 20 Cal. Rptr. 2d 97 (Ct. App. 1993) (reversing jury verdict in favor of plaintiff because plaintiff's security expert established defendant's "abstract negligence" but did not establish a causal link between the negligence and plaintiff's injuries).

[33] *Nola M.*, 20 Cal. Rptr. 2d at 102-03.

[34] Jo Jo's Restaurant, Inc. v. McFadden, 117 S.W.3d 279 (Tex. Ct. App. 2003).

[35] *Id*. at 282.

> such a tort or crime, unless the actor at the time of his negligent conduct should have realized the likelihood that such a situation might be created thereby and that a third person might avail himself of the opportunity to commit such a tort or crime.[36]

As the commentary to Section 448 explains:

> *a.* The rule stated in this Section applies when the actor's conduct creates a situation which is utilized by a third person to intentionally inflict harm upon another or provides a temptation thereto to which the third person yields, the actor having no reason to expect that the third person would so act. Under the rule stated in this Section, the actor is not responsible for the harm thus inflicted merely because the situation which his negligence has created has afforded an opportunity or temptation for its infliction.
>
> *b. When special grounds for anticipating criminal action by third person.* There are certain situations which are commonly recognized as affording temptations to which a recognizable percentage of humanity is likely to yield. So too, there are situations which create temptations to which no considerable percentage of ordinary mankind is likely to yield but which, if created at a place where persons of peculiarly vicious type are likely to be, should be realized as likely to lead to the commission of fairly definite types of crime. If the situation, which the actor should realize that his negligent conduct might create, is of either of these two sorts, an intentionally criminal or tortious act of the third person is not a superseding cause which relieves the actor from liability.[37]

Courts around the country have addressed the issue of causation and superseding causes in cases arising from alleged criminal acts of third parties. The manner in which courts have addressed this issue varies among jurisdictions and is generally case specific.

E. *Comparative Fault / Apportionment*

A vexing question in cases involving criminal acts of third parties is apportionment of fault among the codefendants. A threshold question in analyzing this issue, of course, is whether a particular jurisdiction applies the doctrine of comparative fault and allows for apportionment of damages among joint tortfeasors/codefendants.

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[36] Liberty Nat'l Life Ins. Co. v. Weldon, 100 So. 2d 696, 710 (Ala. 1957) (quoting Restatement (Second) of Torts § 448 (1977)); *see also* Michael L. Roberts & Gregory S. Cusimano, 1 Alabama Tort Law Handbook § 11..03 (5th ed. 2010).

[37] *Id*.

Determining comparative fault and apportionment in cases of this type presents difficult issues, since it involves comparing the fault of an allegedly negligent actor with a party who acted intentionally. While courts in some states have held that fact finders may compare the fault of such parties,[38] other states do not allow for apportionment of fault between negligent and intentional tortfeasors.[39]

In *Riley v. Maison Orleans II, Inc.*,[40] for example, relatives of a deceased nursing home resident alleged that the resident suffered injuries and ultimately died after being attacked with a steel pipe by another of the facility's residents. The trial court ruled that the deceased resident's injuries resulted from the conduct of another resident and from the absence of adequate supervision by the facility, and rendered a substantial damages award against the defendant nursing facility.[41] On appeal, the Court of Appeal of Louisiana specifically noted that "[n]o question exists that but for the actions of [the attacker resident], [the deceased resident] would not have been injured."[42] But, the court held, "the risk created by [the facility] also contributed to plaintiffs' damages" because, according to the facility's own guidelines, the attacker resident was not properly supervised.[43] The trial court thus erred in failing to assign some percentage or degree of fault to the "intentional tortfeasor," the attacker resident.[44] Accordingly, the court reduced the facility's liability to 75% and assessed the wrongdoing resident 25% of the fault.[45]

The United States Court of Appeals for the Ninth Circuit addressed this issue in *Avitia v. United States*.[46] In that case, a patient was sexually assaulted by her doctor at a clinic receiving federal funds and sued the United States under the Federal Tort Claims Act.[47] Applying California law, the trial court held the United States liable because the clinic and its employees failed to provide a chaperone for the patient during the gynecological exam at which the alleged sexual assault occurred.[48] The court found the clinic liable for its own negligence and, under respondeat superior, for the negligence of the physician. The trial court awarded plaintiff $210,000 in noneconomic damages.[49]

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[38] *See, e.g.,* Hutcherson v. City of Phoenix*,* 961 P.2d 449 (Ariz. 1998); Field v. Boyer Co.. L.C., 952 P.2d 1078 (Utah 1998).

[39] *See*, *e.g.*, Whitehead v. Food Max, 163 F.3d 265 (5th Cir. 1998); Merrill Crossings Assocs. v. McDonald, 705 So. 2d 560 (Fla. 1997).

[40] 829 So. 2d 479 (La. Ct. App. 2002)

[41] *Id*. at 486.

[42] *Id*.

[43] *Id.*

[44] *Id*. at 487.

[45] *Id*.

[46] 24 F. App'x 771 (9th Cir. 2001).

[47] *Id*. at 773.

[48] *Id*.

[49] *Id*. at 775.

On appeal, the Ninth Circuit examined the government's argument that the trial court should have apportioned damages between the United States and the physician. Under California law, a defendant's liability for noneconomic damages in personal injury cases is limited to "that defendant's percentage of fault."[50] Thus, according to the court, because the physician's "intentional misconduct" was an "important cause of [plaintiff's] injury," the district court clearly erred when it "disregarded [this] conduct as a contributing factor."[51]

III.
Industry-Specific Scenarios

The courts have developed a large body of case law addressing the liability of business owners for third-party criminal acts in the context of specific industries. Many of these cases involve hospitals and other care facilities. Others involve restaurants, bars, and convenience stores. Still others address the liability of commercial and noncommercial landlords, hotel owners, and a variety of retailers. The principles developed and applied in these cases should apply equally to business owners in other contexts as well.

A. *Hospitals and Other Care Facilities*

One of the most disturbing concerns a hospital, long term care facility, or other health care provider may face is an alleged criminal act committed upon a patient by an employee or third party while the patient is under the provider's care. Because lawsuits claiming injuries arising from such acts have become increasingly common, the issue of hospital or long-term care facility liability for such acts has been addressed by numerous state and federal courts across the country. A sampling of these cases is discussed immediately below. A more detailed discussion of the most significant of these cases from around the country is included as Appendix A at the close of this Article.

Most courts have analyzed these cases using a traditional tort analysis, including analysis of whether the employer-facility owed a duty of care to the patient.[52] Consequently, courts have generally held the health care provider's duty depends upon whether it was foreseeable

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[50] *Id*.; see Cal. Civ. C. § 1431.2 (West 2014).

[51] *Avitia,* 24 F. App'x. at 775.

[52] *See, e.g.,* Doe v. Garcia, 961 P.2d 1181 (Idaho 1998) (defendant hospital owed duty to disclose employee's sexual propensities to plaintiff patient) [this case and its holding were abrogated by the Supreme Court of Idaho in, Hunter v. State of Idaho, 57 P.3d 755, 761 (Idaho 2001); Bullock v. Parkchester Gen. Hosp., 160 N.Y.S.2d 117 (N.Y. Sup. Ct. 1957) (no duty to warn).

that an employee or third party would harm a patient.[53] In analyzing this question, a number of courts have noted that patients are often unable to protect themselves due to mental or physical deficits, including being under the influence of anesthesia or other medications while hospitalized.

In analyzing liability arising out of criminal acts committed by a health care provider's employees, courts have closely examined whether the alleged criminal acts were committed within the course and scope of the employee's employment, which may include a determination whether the actions were performed in furtherance of the employer's interests.[54]

In defending cases involving alleged criminal acts of employees, defense counsel should consider the health care provider's hiring practices, including evidence of reasonable pre-hiring screening efforts. Documentation of such efforts, including written contact with prior employers and performance of thorough background checks, will be beneficial to the defense. Defense counsel should also evaluate all documentation of employee training—including repeat training and continued in-servicing of all employees—with respect to the employer's policies regarding substance abuse, physical abuse, sexual misconduct, and related issues.[55]

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[53] *See Ex parte* S. Baldwin Reg'l Med. Ctr., 785 So. 2d 368 (Ala. 2000) (holding plaintiffs did not satisfy burden of establishing hospital should have foreseen nurse would probably sexually assault plaintiffs' minor child, a patient of the hospital, where there was no evidence nurse employed by Defendant hospital had previously engaged in sexual misconduct before incident at issue); L.J. v. Peng, No. CO-96-2197,1997 WL 228960 (Minn. Ct. App. May 6, 1997) (affirming summary judgment for defendant health care provider on grounds there was no evidence sexual contact between its employee and patient was a foreseeable risk of the employee's employment); c*f.* Bezark v. Kostner Manor, Inc., 172 N.E.2d 424 (Ill. Ct. App. 1961) (nursing facility should have reasonably anticipated reasonable likelihood intoxicated resident who wandered around facility could injure other residents, including plaintiff); Juhnke v. Evangelical Lutheran Good Samaritan Soc'y, 634 P.2d 1132 (Kan. Ct. App. 1981) (reversing judgment for nursing facility where facility had knowledge of propensity of resident to act violently prior to incident at issue); Eckhardt v. Charter Hosp. of Albuquerque, Inc., 953 P.2d 722 (N.M. Ct. App. 1997) (evidence supported verdict against hospital on negligence claim where staff members knew of employee's past substance abuse problems and lack of clinical experience).

[54] *See* E. Alabama Behavioral Med., P.C. v. Chancey, 883 So. 2d 162, 166 (Ala. 2003) (employer not liable for intentional acts of employee unless acts were "committed within the scope of the employee's employment or were done to further the interest of the employer"); Doe v. Samaritan Counseling Ctr., 791 P.2d 344 (Alaska 1990) (time and place of alleged tortious conduct was sufficiently related to employee's work to permit recovery on respondeat superior theory); Richard H. v. Larry D., 243 Cal. Rptr. 807 (Ct. App. 1988) (physician was acting within course and scope of employment at time of sexual relationship with patient); Hoover v. Univ. of Chicago Hosps., 366 N.E.2d 925 (Ill. Ct. App. 1977) (physician's intentional sexual assault of patient could not be interpreted as an act in furtherance of hospital employer's business); Cosgrove v. Lawrence, 522 A.2d 483 (N.J. Super. Ct. App. Div. 1987) (sexual relations with patient are not the kind of conduct that social worker therapist was employed to perform within scope of employment such that employer was immune from vicarious liability).

[55] Health care providers and their counsel should also consider collateral criminal and regulatory issues and proceedings that frequently accompany civil suits arising from criminal acts committed on patients. These collateral proceedings can result in regulatory citations to the health care provider, licensure problems, civil monetary penalties and fines, and even criminal prosecution.

With respect to third parties, a critical question is whether the health care provider has taken reasonable steps to protect patients from criminal acts of those persons lawfully on the premises, such as vendors and visitors, and those who may enter the premises unlawfully. In defending cases of this nature, defense counsel should consider evidence of all protective measures employed by the health care provider, including locking mechanisms on doors and windows, security cameras, use of security personnel, and sign-in logs. Evidence of such measures can be utilized effectively in defending liability claims based on alleged third-party criminal conduct. At the same time, however, counsel must investigate whether the facility opted to employ such mechanisms because of prior instances of criminal activity; if so, that fact could be used by the plaintiff to establish foreseeability and, thus, a duty on the part of the facility owner.

B. *Restaurants, Bars, and Convenience Stores*

Armed robbery is a common problem in cases involving restaurants, bars, and convenience stores. There are a number of industry studies regarding the effectiveness of certain security measures, such as the presence of surveillance cameras, having more than one employee on duty during nights shifts, the use of drop boxes and time delay safes, closing procedures, etc. In addition, OSHA has promulgated specific and detailed regulations concerning late-night retail establishments. Defendants must be aware of these studies and regulations, as plaintiffs may attempt to use them to establish a standard of care.

Moreover, business owners must understand how the dynamics change when alcohol is added to the equation. Among other considerations, business owners must be aware of interactions between patrons and between patrons and employees. The owner should have in place, and strictly adhere to, policies regarding how and when customers are expelled from the establishment, what happens once they are expelled, and under what circumstances the police are called.

C. *Apartments and Condominiums*

The primary theories of liability pursued by plaintiffs against landlords or condominium owners are failure to keep the premises reasonably safe (i.e., maintenance issues) or failure to provide adequate security. Among the critical issues the defendants must consider are key control, access control, and screening of employees, such as maintenance personnel, who may have access to tenants' apartments. Another important consideration is whether the landlord is responsible for repairs, particularly those relating to security and safety. Counsel should also be mindful of the presence (or state of repair) of locks, windows, and security bars.

D. *Hotels and Motels*

The types and availability of key control and locks are critical in cases involving injuries resulting from criminal misconduct in hotels and motels. Among other important issues, defendants must consider whether the locks are changed after each guest checks out and whether the hotel/motel properly screened employees with access to master keys or other access to guests and their rooms.

E. *Shopping Centers and Other Retailers*

The most important issues in cases against shopping centers and other retailers are access control and the presence or absence of security guards. The existence of adequate lighting is also critical, as is any history of prior crimes.

IV.
Insurance Coverage Implications

A. *Where is the Coverage?*

1. General Considerations

Liability cases arising out of criminal misconduct by third parties often involve a physical assault on an occupant of or visitor to the premises. The perpetrator may be an employee, an independent contractor servicing the premises, a patron or visitor, or a stranger. When sued, the business or premises owner will look to its liability insurance carrier to protect it from claims presented by the assaulted party. Such protection will include a defense to the claims asserted and, if necessary, funds required to settle the claims or satisfy any judgment. While an in-depth treatment of insurance coverage issues is beyond the scope of this Article, the owner should be aware of some of the most common issues that must be addressed when analyzing the role of liability insurance in such claims.

First, the business or premises owner should provide its liability insurer with *prompt notice* of the incident, regardless of whether the owner believes any resulting claim will or will not be covered. Because timely notice is typically a specific condition of coverage,[56] failing to provide such notice may jeopardize the available coverage.

Second, to the extent the premises is leased to another party, the premises owner (or its counsel) should carefully *review the lease* to determine whether it requires the lessee to name the owner (lessor) as an "additional insured" and/or to provide the owner with a Certificate of Insurance. If it does, the owner should immediately place the lessee's liability insurer on notice of the incident (in addition to, not instead of, its own insurer).

Third, the premises owner should *review the lease's indemnity provisions* to ascertain whether the lessee is required to indemnify the lessor for liability arising out of the lessee's use of the premises. If so, the owner should formally present a contractual indemnity claim to the lessee and/or its liability insurance carrier. The same process should also be followed with respect to any security company hired by the lessor or lessee to provide security to the premises.

2. Standard Insuring Agreements

A critical question in determining the availability of potential coverage is whether the claim asserted against the owner is within the scope of the relevant policy's insuring

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[56] *See infra* text accompanying note 61.

agreement. The standard ISO commercial general liability (CGL) policy provides coverage for the insured's liability for "damages because of 'bodily injury' or 'property damage'" arising out of an "occurrence" (generally defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions") (Coverage A), as well as liability for "damages because of 'personal and advertising injury'" arising out of any of several specified offenses, including, as relevant here, "false arrest, detention and imprisonment" (Coverage B).[57]

Most "garden variety" injuries arising from third-party criminal conduct will constitute "bodily injury" arising out of an "occurrence" within the meaning of a CGL policy, so it will generally not be difficult for the owner to meet the threshold of establishing a loss within the scope of the policy's basic coverage. However, specific fact patterns may raise more nuanced questions that require further analysis. For example:

1. An assailant points a gun and snatches the purse off of the claimant's shoulder. Does this assault constitute "bodily injury"?
2. Is a claim alleging only emotional distress a claim for "bodily injury"?
3. Is holding the plaintiff at gunpoint while stealing his or her belongings a "detention" under the policy's "personal and advertising injury" coverage?

B. *Who is an Insured?*

Another critical question in analyzing insurance coverage is whether the property owner seeking coverage is an "insured" under the relevant policy. The owner will, of course, be a Named Insured under its own policy; and, depending on the form of the owner's business entity, the definition of insured may include the owner's spouse (when the owner is named as an individual); the owner's partners (if a partnership); members of a limited liability company (if an LLC); directors and officers of a corporation; etc.[58] In addition, "employees" of the insured owner acting within the scope of their employment and "volunteer workers" performing duties related to the insured's business may also qualify as insureds.[59] Thus, in cases in which an employee or volunteer worker is named as a defendant, it must be determined at the outset whether the employee/volunteer worker was acting in the course of employment or in the conduct of the insured's business.

When the owner seeks coverage under the policy of another, such as a lessee, it may qualify as an insured under an Additional Insured endorsement to the lessee's policy. If applicable, such an endorsement modifies the definition of "insured" in the policy to include the owner (landlord) "with respect to liability arising out of the ownership . . . of that part of

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[57] *See* Appendix B, § I at the close of this Article.

[58] *See id.*, § II.

[59] *See id.*

the premises leased" to the lessee.[60] In that circumstance, it will be necessary to determine not only whether the premises owner is an additional insured but also whether the injury-producing criminal act took place on that part of the premises subject to the lease (e.g., inside the leased premises rather than in an adjacent parking lot).

C. *Potential Coverage Limitations*

Even if the claim is asserted against an "insured" and alleges damages because of "bodily injury" or "personal or advertising injury," various provisions of the policy may preclude or limit coverage.

1. Conditions

CGL policies contain a number of conditions to coverage. Theoretically, at least, the insured's failure to comply with these conditions could allow the insurer to avoid its coverage obligations under the policy.

a. Notice

Virtually all CGL policies contain a condition requiring the insured to notify the insured of an "occurrence," "claim," or "suit" "as soon as practicable." This condition also sets forth the information the insured must provide in each instance.[61] The purpose of this condition is to allow the insurer to investigate the facts giving rise to the insured's potential liability at the earliest opportunity.

Most states require that a liability carrier show it was prejudiced by the insured's failure to comply with the notice condition before it may invoke breach of the condition as a way to avoid coverage. However, prejudice may be easier to establish in premises liability cases arising out of third-party criminal conduct than in many other cases. For example, many locations now have surveillance cameras, and the alleged incident may have been captured on videotape. The failure to provide notice of the incident, and thus to allow the insurer to preserve and secure such video evidence and to conduct its investigation armed with such evidence, may amount to prejudice.

b. Other Insurance

Another liability policy condition that will likely be implicated is the Other Insurance provision. This provision defines when the policy at issue is to be construed as primary insurance and when it may be considered excess insurance vis-à-vis other applicable policies.[62] This distinction is relevant both as to the insurer's duty to provide a defense and to how any losses will be apportioned among responsible insurers.

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[60] *See id.*, § III.

[61] *See id.*, § IV.A.

[62] *See id.*, § IV.B.

As relevant to the claims at issue in this Article, the business or premise owner's policy is generally considered primary, with the exception of "[a]ny other primary insurance available to [the owner] covering liability for damages arising out of the premises or operations for which [the owner has] been added as an additional insured by attachment of an endorsement."[63] In other words, when the premises owner is an additional insured under a lessee's policy, the premises owner's liability policy will be treated as excess to the lessee's liability policy. Thus, it will be the lessee's insurer that will be required to provide the owner a defense and, assuming coverage, to fund any settlement or judgment, at least up to the applicable policy limits.

Even if the owner's policy is considered primary, the Other Insurance provision will generally detail the manner in which claims will be apportioned among other primary policies.[64]

2. Exclusions

The most obvious limitations to coverage are contained in the policy's exclusionary language. The following are potentially applicable exclusions under the "bodily injury" coverage (Coverage A) of the standard CGL policy:[65]

- Expected or Intended Injury
- Liquor Liability

Under the "personal and advertising injury liability" coverage (Coverage B), the following exclusions may apply:[66]

- Knowing Violation of Rights of Another
- Criminal Acts

In addition to these standard exclusions, many liability policies written on risks such as bars, garden apartment complexes, or habitational risks in high crime areas specifically add "assault and battery" to the list of excluded conduct.[67] In some cases, such exclusions do not preclude coverage for an "innocent" insured versus the actual insured assailant (e.g., an "employee" or "volunteer worker").

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[63] *See id.*

[64] *See id.*

[65] *See id.*, § V.A.

[66] *See id.*, § V.B.

[67] *See id.*, § V.C.

D. *The Indirect Route to Defense Expense Coverage*

1. Contractual Liability Coverage

Even when a business or premises owner is not a named additional insured under the policy of a lessee or security company, the "contractual liability" coverage of the lessee's or security company's liability policy may obligate it to provide the owner a defense. The contractual liability provision provides coverage for damages the insured must pay "by reason of the assumption of liability" in an "insured contract," including "reasonable attorney fees and necessary litigation expenses incurred by or for a party other than an insured."[68] As relevant here, "insured contract" includes "[a] contract for a lease of premises" and "[t]hat part of any other contract or agreement pertaining to [the insured's] business . . . under which [the insured] assume[s] the tort liability of another party to pay for 'bodily injury' or 'property damage' to a third person or organization."[69] Thus, if there is an agreement requiring the lessee or security company to indemnify the owner for tort liability related to the leased premises or to the conduct of business on behalf of the owner, the owner should be sure to present a contractual liability claim to the other party.

2. Supplementary Payments

A CGL policy also contains a "supplementary payments" condition that obligates the insurer to pay for defense expenses incurred by an indemnitee of the insured under an "insured contract," as defined above, subject to certain conditions.[70] These include the condition that no conflict exists between the business owner (indemnitee) and insured (indemnitor), thereby allowing the same attorney to represent both parties in the litigation.

* * *

The policy provisions discussed above, while typical of those that may arise in a premises liability claim arising out of third-party criminal conduct, are by no means exhaustive of those implicated in such a claim. Because the provisions of relevant insurance policies can vary widely, such policies must be reviewed carefully, as must any potentially applicable leases and security contracts, to ensure that all coverage and contractual legal remedies may be aggressively pursued.

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[68] *See id.*, § IV.C.

[69] *See id.*

[70] *See id.*, § IV.D.

Appendix A

Health Care Providers' Civil Liability for Harm to Patients from Criminal Acts of Third Parties and Employees

The following is an overview of case law from jurisdictions around the country addressing the issue of civil liability of health care providers based upon alleged criminal acts to patients in health care facilities by the providers' employees or by third parties. As illustrated below, the courts have taken a number of approaches toward health care provider liability under these circumstances.

Alabama

Alabama's appellate courts have addressed health care provider liability for criminal acts of employees and third parties in several cases. As a general rule, under Alabama law, "an employer is not liable for the intentional acts of its employee unless the acts were committed within the scope of the employee's employment or were done to further the interests of the employer."[71] An employer, however, may be liable for the unlawful or intentional acts of an employee if the employer "ratifies" the acts by expressly adopting or implicitly approving the behavior.[72]

East Alabama Behavioral Medicine, P.C. v. Chancey involved allegations of sexual activity between a former patient of the defendant employer and the patient's treating psychiatrist. The Alabama Supreme Court held that an employee's misconduct is "wholly outside" the scope of employment where it is not done in furtherance of the employer's business, but for the employee's "personal gratification."[73]

In *Ex parte South Baldwin Regional Medical Center*, plaintiffs sued a hospital after a nurse employed by the hospital sexually abused their minor child, a patient of the hospital.[74] The trial court granted summary judgment for the hospital.[75] On appeal, the Alabama Supreme Court held there was no evidence that the nurse had engaged in sexual misconduct before

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[71] E. Alabama Behavioral Med., P.C. v. Chancey, 883 So. 2d 162, 166 (Ala. 2003).

[72] *Id*. at 169.

[73] *Id*. at 167; *see also Ex Parte* Atmore Comm. Hosp., 719 So. 2d 1190, 1194 (Ala. 1998) (holding "no corporate purposes could conceivable be served" where wrongful behavior was aimed at "satisfying [employee's] own lustful desires"); Hendley v. Springhill Mem'l Hosp., 575 So. 2d 547, 548-49 (Ala. 1990) (patient sued hospital for conduct of hospital vendor performing unauthorized vaginal exam of patient and appellate court concluded "assault . . . was not an act which was fairly incident to the relationship, nor was it in promotion of [employee's] duties . . . . Rather, the act alleged was wholly aside from the business of [employer] and the alleged act, if committed, was done on [employee's] own behalf and not pursuant to his duties.").

[74] 785 So. 2d 368, 369 (Ala. 2000)

[75] *Id*.

the incident and, as such, plaintiffs failed to establish the hospital should have foreseen the nurse would assault a child.[76]

Doe v. Swift involved a patient's action against the State of Alabama to recover on a judgment obtained in federal court against a State psychologist for damages the patient sustained as a result of the psychologist's sexual assault while the patient was involuntarily committed.[77] On appeal, the Alabama Supreme Court held the psychologist's actions were not taken for the benefit of his employer (the State) or in performance of his duties; thus, the State was not responsible for paying the judgment entered against the psychologist. In reaching this decision, the court noted "[t]here are numerous other cases holding that sexual misconduct by an employee is purely personal and outside the line and scope of his employment."[78]

Alabama courts have also addressed criminal sexual assaults by third parties. In *Young v. Huntsville Hospital*, for example, a patient sued the defendant hospital alleging a trespasser sexually assaulted her while she was anesthetized at the hospital.[79] The trial court directed a verdict in favor of the hospital.[80] On appeal, the Supreme Court of Alabama examined "whether a hospital or other health care facility owes a duty to protect its sedated or anesthetized patients from third-party criminal acts."[81] The court noted the general rule that absent "special relationships or circumstances, a person has no duty to protect another from criminal acts of a third party."[82] However, according to the court, such a special relationship did exist between the plaintiff and the hospital because the plaintiff was "anesthetized or sedated and therefore unable, or less able, to protect herself from an assault . . . ." "[W]e can hardly imagine a situation," the court stated," in which a person is more dependent on another for basic bodily protection and care than the situation of an anesthetized or sedated patient."[83]

Alaska

The Supreme Court of Alaska addressed a provider's liability in *Doe v. Samaritan Counseling Center*.[84] *Doe* involved a patient's suit against a counseling center seeking to hold the counseling center liable under a respondeat superior theory for sexual acts of a

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[76] *Id*. at 371.

[77] 570 So. 2d 1209, 1210 (Ala. 1990)

[78] *Id*. at 1211.

[79] 595 So. 2d 1386, 1387 (Ala. 1992),

[80] *Id*.

[81] *Id*.

[82] *Id*. (citation and emphasis omitted).

[83] *Id.* at 1389.

[84] 791 P.2d 344 (Alaska 1990).

therapist employed by the counseling center.[85] The plaintiff-patient, who was admitted for "emotional and spiritual therapy," alleged that pastoral counselors employed by the counseling center kissed, fondled, and engaged in sexual intercourse with her while she was a patient.[86] The trial court entered summary judgment in favor of the center.[87] On appeal, the Alaska Supreme Court held that respondeat superior liability was not precluded simply because the employee's alleged tortious acts were sexual in nature; to the contrary, the time and place of the alleged tortious conduct was sufficiently related to the employees' work to permit imposition of respondeat superior liability.[88]

Arizona

Doctors Hospital, Inc. v. Kovats involved a patient's claims against her doctor and hospital for injuries sustained when the patient was struck with a chair by another patient who had escaped from restraints.[89] The trial court granted the doctor's motion for directed verdict but entered a judgment against the hospital.[90] The evidence established that the patient who struck the plaintiff had extricated himself from restraints on at least five prior occasions and that, had the restraints been properly applied, the patient would not have been able to escape from them.[91] Based on this evidence, the Arizona Court of Appeals held there was sufficient evidence to find that the hospital was negligent and affirmed the judgment.[92]

Arkansas

In *Sparks Regional Medical Center v. Smith*, a patient admitted for psychiatric treatment at a psychiatric medical center was assaulted by an employee of the center and brought a medical malpractice claim against the medical center.[93] The trial court entered judgment on a jury verdict in favor of the patient. The Arkansas Court of Appeals affirmed. The evidence supported a finding that the medical center had been negligent in supervising the employee following prior reports of abuse of other psychiatric patients and that the facility was therefore liable for the employee's conduct and sexual assault on the plaintiff.

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[85] *Id*. at 345.

[86] *Id*.

[87] *Id*. at 346.

[88] *Id*. at 348.

[89] 494 P.2d 389, 389-90 (Ariz. Ct. App. 1972).

[90] *Id.* at 389.

[91] *Id*. at 390.

[92] *Id*.

[93] 976 S.W.2d 396 (Ark. Ct. App. 1998).

California

In several California cases, the appellate courts have held that sexual relations between a patient and health care provider may arise out of the health care provider's employment, such that a hospital or employer may be liable for the individual health care provider's actions. For example, in *Richard H. v. Larry D.*, the Court of Appeal analyzed a patient's fraud, professional negligence, and negligent infliction of emotional distress claims against a physician and the hospital that employed the physician.[94] According to the complaint, the physician had "surreptitious sexual relations" with the patient's wife while under the care of the physician "for purposes of receiving marital counseling."[95] The trial court entered judgment for the physician and hospital.[96] The court of appeal reversed, holding that the patient's claim of professional negligence against the hospital was valid because the physician was acting within the course and scope of his authority as head of the hospital's psychiatry department at the time of the sexual relations and was providing services on behalf of himself and the hospital.[97]

In *Mast v. Magpusao*, the appellate court examined a nursing home resident's claims against a nursing facility arising out of injuries caused by another resident of the facility.[98] The trial court entered a judgment of nonsuit against the plaintiff. On appeal, a central question for the court was whether the plaintiff's claims were for ordinary or professional negligence; if the latter, expert testimony was required.[99] Finding the claims to be for ordinary negligence, the court held that expert testimony was not required.[100] However, because the question whether the nursing home proprietor was negligent in failing to protect plaintiff presented a question of fact, nonsuit was improper and the judgment was reversed.[101]

Inderbitzen v. Lane Hospital involved a lawsuit by a husband and wife against a hospital and numerous defendant physicians.[102] The plaintiffs alleged that the wife, while admitted to the defendant hospital to deliver a child, was subjected to numerous unauthorized vaginal and rectal examinations by at least ten to twelve individuals.[103] In addressing the hospital's liability, the court noted "[i]t is revolting to the sense of decency to think of a woman in

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[94] 243 Cal. Rptr. 807 (Ct. App. 1988) (disagreed with by *John R. v. Oakland Unified Sch. Dist.*, 256 Cal. Rptr. 766 (1989)).

[95] *Id*. at 584.

[96] *Id*.

[97] *Id*. at 596.

[98] 225 Cal. Rptr. 689, 689 (Ct. App. 1986).

[99] *Id*.

[100] *Id*.

[101] *Id*.

[102] 12 P.2d 744 (Cal. Ct. App. 1932).

[103] *Id*. at 747.

confinement, necessarily disrobed, being subjected to what must have been at least thirty or forty most intimate physical examinations at the hands of ten or twelve different men, and being treated with disrespect when she protested at such treatment."[104] Based on this analysis, the court reversed the trial court's order granting a nonsuit in favor of the defendants.[105]

Connecticut

In *Morales v. St. Francis Hospital and Medical Center*, the Appellate Court of Connecticut addressed a police officer's claims after he was injured by a patient who freed himself from restraints, escaped from a hospital, and injured the officer.[106] The officer sued the hospital, and the trial court entered judgment on a jury verdict in favor of the hospital.[107] On appeal, the court noted there was evidence that the patient was "violently psychotic,"[108] but nonetheless affirmed the verdict.

Florida

In *Coleman v. Mercy Hospital, Inc.*, the Florida Court of Appeals examined a nurse's suit against the hospital that employed her after she was injured by a senile patient.[109] The trial court granted the hospital's motion for summary judgment, and the nurse appealed.[110] On appeal, the court held the hospital did not have a duty to warn the nurse because it had no knowledge of the patient's propensity for violence and the patient's prior history did not indicate he was likely to injure the nurse or any other hospital employee.[111] Notably, however, the court's analysis leaves open the possibility that Florida courts may find a duty to warn where the hospital has affirmative proof or knowledge a patient is likely to behave violently toward his or her caregivers.

Georgia

In *Harrison v. Piedmont Hospital, Inc.*, the Court of Appeals of Georgia examined a wife's suit for damages for loss of consortium against a hospital where her husband was a patient.[112] The wife alleged her husband's genitals were injured in an attack by an operating room technician during the course of an operation on the husband's knee.[113] The trial court

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[104] *Id*.

[105] *Id*.

[106] 519 A.2d 86 (Conn. App. Ct. 1987).

[107] *Id*. at 87.

[108] *Id*. at 88.

[109] 373 So. 2d 91, 91 (Fla. Dist. Ct. App. 1979).

[110] *Id*.

[111] *Id*.

[112] 274 S.E.2d 72 (Ga. Ct. App. 1980).

[113] *Id*. at 73.

granted a judgment notwithstanding the verdict in favor of the defendants after the jury returned a $1,000 verdict for the plaintiff.[114] The Court of Appeals affirmed the judgment, holding that the evidence did not support a finding that defendants were negligent in hiring and supervising the technician or that the defendant surgeon was negligent in failing to observe the technician at the time of the attack.[115]

Illinois

Hoover v. University of Chicago Hospital involved a patient's claim against a hospital and doctor for malpractice and assault based on allegations the doctor sexually assaulted the plaintiff while examining her.[116] The plaintiff claimed the doctor was acting as an agent or employee of the hospital when he committed these acts.[117] The trial court dismissed the vicarious liability claims against the hospital.[118] The Appellate Court of Illinois affirmed, holding that the alleged intentional sexual assault by the doctor could not be interpreted as an act in furtherance of the hospital's business and thus could not give rise to a cause of action against the hospital.[119]

Previously, in *Bezark v. Kostner Manor, Inc.*, the Illinois appellate court examined a nursing home resident's claims against a nursing facility for injuries sustained when she was assaulted by an intoxicated fellow resident.[120] Although the appellate court's opinion largely addressed evidentiary issues, the court specifically noted that "[n]ursing homes and similar institutions for the aged cannot be held to be insurers of the safety of their patents" and that nursing facilities "owe their patients ordinary care to protect them from any danger or injury which might be reasonably anticipated."[121] However, "[a]s to dangers reasonably to be anticipated from acts of other persons under the hospital's control, reasonable care and attention must be exercised for the safety and well-being of their patients, in proper proportion to the circumstances and their ability to look after their own safety."[122] Thus, "[w]here there is greater danger and hazard, there must be a corresponding exercise of attention for the purpose of preventing injury to another . . . ."[123] The court also observed that

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[114] *Id*.

[115] *Id*. at 74.

[116] 366 N.E.2d 925, 926 (Ill. App. Ct. 1977).

[117] *Id*. at 928

[118] *Id*.

[119] *Id*. at 929.

[120] 172 N.E.2d 424, 425-26 (Ill. App. Ct. 1961).

[121] *Id*. at 426.

[122] *Id*.

[123] *Id*.

the defendant facility, in the exercise of ordinary care, could have reasonably anticipated the likelihood that while in an intoxicated condition, the resident might wander around the nursing facility and injure other residents.[124]

Indiana

Murphy v. Mortell involved a patient's claims that she was sexually molested by a hospital technician while unconscious.[125] The plaintiff sued the hospital and ultimately settled her claims.[126] Thereafter, she filed a petition with the Department of Insurance for payment of excess damages from the Patient's Compensation Fund.[127] The trial court granted summary judgment for the Department.[128] The Court of Appeals of Indiana affirmed on the ground the claims did not constitute medical malpractice and thus were not governed by the Indiana Medical Malpractice Act.[129]

More recently, in *Anonymous Hospital v. Doe*, the Indiana appellate court reached the opposite conclusion. The court addressed a female psychiatric patient's claim to the Department of Insurance after she was allegedly sexually attacked by a male patient.[130] Plaintiff also brought negligence claims against the hospital.[131] The trial court granted the plaintiff's motion for partial summary judgment on the ground the claims against the hospital sounded in ordinary negligence.[132] The Indiana appellate court reversed and remanded, holding that the claims were for medical malpractice and thus governed by the Medical Malpractice Act.[133]

Kansas

In *Juhnke v. Evangelical Lutheran Good Samaritan Society*, the Court of Appeals of Kansas analyzed claims filed by the guardian and conservator of a nursing home resident against a nursing home for personal injuries the resident sustained from an assault by a fellow resident.[134] The trial court directed a verdict for the defendant nursing facility. On

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[124] *Id*. at 427.

[125] 684 N.E.2d 1185, 1186 (Ind. Ct. App 1997).

[126] *Id*.

[127] *Id*. at 1187.

[128] *Id*.

[129] *Id*. at 1188 (holding "although the acts occurred during [plaintiff's] confinement to the hospital, the acts were not designed to promote her health and did not call into question [the defendant physician's] use of skill or expertise as a health care provider").

[130] 996 N.E.2d 329 (Ind. Ct. App. 2013).

[131] *Id*. at 331.

[132] *Id*. at 332.

[133] *Id*.

[134] 634 P.2d 1132, 1133 (Kan. Ct. App. 1981).

appeal, the Court of Appeals of Kansas held the evidence indicated the plaintiff resident was injured at the facility; the injury resulted from a fall she sustained as a consequence of the other resident pushing her; and, prior to the incident, the nursing facility had knowledge of the propensity of the other resident to conduct herself in a belligerent and violent fashion.[135] The court held this evidence was sufficient to establish the nursing facility's breach of duty and reversed and remanded the case.[136]

Kentucky

University of Louisville v. Hammock involved injuries plaintiff allegedly sustained while a patient at the university hospital.[137] The plaintiff claimed she was injured by another patient who was demented or partially demented and who was negligently permitted to escape from his room, wander into plaintiff's room, and assault her.[138] The trial court entered a judgment for the plaintiff.[139] The Court of Appeals of Kentucky affirmed the judgment, holding that the defendant negligently permitted the demented patient to escape from his room and assault the plaintiff.[140]

Louisiana

In *Collier v. AMI, Inc.*, the Court of Appeal of Louisiana addressed the claims of a 74-year-old female resident against a nursing facility for injuries, mental anguish, and humiliation she sustained as a result of an alleged sexual assault committed upon her in the defendant facility.[141] Plaintiff alleged the facility failed to provide reasonable and proper security for residents and failed to timely respond to her injuries.[142] The trial court entered judgment for the defendant. The Court of Appeal affirmed, holding that the fact that purported prowlers had entered the premises in the months preceding the alleged assault did not establish the facility was negligent in providing security to plaintiff.[143] The court also determined the staff timely and appropriately responded to the incident and to plaintiff's injuries.[144]

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[135] *Id.* at 1136.

[136] *Id*.

[137] 106 S.W. 219, 219 (Ky. Ct. App. 1907).

[138] *Id*.

[139] *Id*.

[140] *Id*. at 221.

[141] 254 So. 2d 170, 170-71 (La. Ct. App. 1971).

[142] *Id*. at 171-72.

[143] *Id*. at 172.

[144] *Id*.

Free v. Franklin Guest Home, Inc. involved a nursing home resident's suit against the facility for breach of contract and negligence arising out of a variety of claims, including an alleged sexual assault at the facility.[145] The jury found against the plaintiff on the sexual assault claim, and he filed motions for judgment notwithstanding the verdict and for a new trial. On appeal of the denial of these motions, the Louisiana appellate court held that no direct evidence was presented to support the plaintiff resident's claim that he was sexually assaulted by another male resident or that the male resident ever struck or attempted to strike the plaintiff.[146]

In *Samuels v. Southern Baptist Hospital*, a patient sued a hospital for damages caused when the patient was sexually assaulted by a nursing assistant in the hospital's psychiatric unit.[147] The trial court entered a $450,000 judgment for the plaintiff. The appellate court affirmed the judgment on appeal on the ground the hospital was vicariously liable for the nursing assistant's conduct.[148] According to the court, "[e]nsuring a patient's well-being from others, including staff, while the patient is helpless in a locked environment is part of the hospital's normal business." Thus, even though the nursing assistant's tortious conduct was "totally unauthorized by the employer and motivated by the employee's personal interest," it was nonetheless "reasonably incidental to the performance of his duties as a nurse's assistant."[149]

In *Riley v. Maison Orleans II, Inc.*, relatives of a deceased nursing home resident filed a negligence and wrongful death action against the facility after their decedent sustained serious injuries and died as a result of being attacked with a steel pipe by another resident.[150] The trial court entered judgment in favor of the plaintiffs in the amount of $700,000.[151] The Louisiana Court of Appeal affirmed, holding that the nursing home's actions were the direct cause of the resident's injuries because the resident who assaulted plaintiffs' decedent should have been checked by staff at least every two hours. Instead, the attack occurred while nursing home aids were asleep in the recreation room.[152]

More recently, in *W.P. v. Universal Health Services Foundation*, the parents of a minor child sued a hospital for negligence in failing to prevent a sexual assault on the child while a patient of the hospital.[153] The hospital filed a dilatory exception of prematurity based on lack

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[145] 463 So. 2d 865, 867-68 (La. Ct. App. 1985).

[146] *Id*.

[147] 594 So. 2d 571 (La. Ct. App. 1992).

[148] *Id*. at 573.

[149] *Id*. at 574.

[150] 829 So. 2d 479 (La. Ct. App. 2002).

[151] *Id*. at 485.

[152] *Id*. at 486. The court also held that an attack on a nursing home resident by another resident does not constitute sexual or physical abuse within the meaning of the sexual and/or physical abuse exclusion of the nursing home's liability insurance coverage. *Id*. at 490.

[153] 91 So. 3d 1097, 1098 (La. Ct. App. 2012).

of review by a medical review panel.[154] The trial court granted the exception.[155] The court of appeal held the parents' claims fell within the scope of the Louisiana Medical Malpractice Act and, thus, the parents were required to present their allegations to a medical review panel before filing a civil suit against the hospital.[156]

Minnesota

Thelen v. St. Cloud Hospital involved the sexual abuse of a 19-year-old female patient of the defendant hospital by a hospital employee.[157] The plaintiff sought to impose liability on the hospital for failing to report the employee's sexual abuse of the patient under the Vulnerable Adult Act, which imposes absolute liability for damages caused by the violator's failure to report abuse of vulnerable adults.[158] The district court entered a judgment for the patient.[159] The Court of Appeals of Minnesota affirmed, finding the Act imposed absolute liability on the hospital.[160]

In *L.J. v. Peng*, the appellate court affirmed summary judgment in favor of a health care provider (an acupuncturist) and chiropractic clinic.[161] The plaintiff's claims arose out of alleged nonconsensual sexual contact by a clinic employee while plaintiff underwent treatment at the clinic.[162] On appeal, the plaintiff argued that fact questions existed as to whether the clinic was vicariously liable for the employee's conduct and whether the clinic was negligent in hiring, retaining, and supervising the employee.[163] In affirming the judgment, the appellate court held there was no evidence that sexual contact between the acupuncturist and plaintiff was a foreseeable risk of the acupuncturist's employment with the clinic and that such contact was unrelated to the treatment he was employed to perform.[164] The court also held there was insufficient evidence for a jury to conclude it was foreseeable the acupuncturist would assault a patient.[165] With respect to the negligent hiring claim, the court

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[154] *Id*.

[155] *Id*.

[156] *Id*. at 1099.

[157] 379 N.W.2d 189, 190 (Minn. Ct. App. 1985).

[158] *Id*. at 190 (citing MINN. STAT. § 626.557).

[159] *Id*.

[160] *Id*. at 194; *see also* Marston v. Minn. Clinic of Psychiatry & Neurology, Ltd., 329 N.W.2d 306, 311 (Minn. 1982) (issue of whether employer is responsible for employee's sexual acts during therapy sessions depends on fact question of whether acts were foreseeable, related to, and connected with acts otherwise within scope of employment).

[161] No. CO-97-2197, 1997 WL 228960 (Minn. Ct. App. May 6, 2007).

[162] *Id*. at *1.

[163] *Id*.

[164] *Id*. at *2.

[165] *Id*.

held that "[a]n employer need not check an applicant's criminal history if 'the employer has made adequate inquiry or otherwise has a reasonably sufficient basis to conclude the employee is reliable and fit for the job.'"[166]

Mississippi

In *Dupree v. Plantation Pointe, L.P.*, plaintiff sued a nursing facility on behalf of herself and her mother, a resident of the facility, after her mother was sexually assaulted by another resident.[167] The jury returned a verdict in favor of the nursing facility.[168] The Mississippi Supreme Court held that substantial evidence supported the jury's verdict. Of note to the court was the fact that the resident who allegedly assaulted the mother had dementia, but the nursing facility had only limited authority to transfer "problematic" residents.[169] The court also observed that although the attacker had his pants down, his penis out, and was on top of the plaintiff resident, there was no evidence that any sexual touching or rape had occurred and the Department of Health had found the nursing facility was not negligent in its treatment and protection of the resident.[170]

New Jersey

Cosgrove v. Lawrence involved respondeat superior claims against the employer of a therapist by a patient seeking to hold the employer liable for the therapist's misconduct in entering into a sexual relationship with the patient.[171] The trial court dismissed the complaint. On appeal, the Superior Court of New Jersey held that sexual relations with a patient were not within the scope of the therapist's employment and, thus, the therapist's employer was immune from vicarious liability. Notably, in his deposition, the therapist testified that such sexual relations constituted improper conduct on his part, "were never meant to be part of therapy," could not be justified as part of therapy, and were not used "as a treatment technique in any way."[172] Further, when asked what he thought he would accomplish by having sex with his patient, the therapist answered "[n]othing."[173]

New Mexico

In *Stake v. Woman's Division of Christian Service*, a nurse filed suit against a physician and hospital for personal injury sustained by the nurse while caring for an unruly patient at

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[166] *Id*. at *3.

[167] 892 So. 2d 228, 230 (Miss. 2005).

[168] *Id*.

[169] *Id*. at 232.

[170] *Id*. at 233.

[171] 522 A.2d 483 (N.J. Super. Ct. App. 1987).

[172] *Id*. at 484.

[173] *Id.*

the doctor's request.[174] The trial court entered judgment for the defendants.[175] On appeal, the Supreme Court of Mexico held the defendant physician could not be considered negligent in failing to warn the plaintiff of the allegedly dangerous propensities of the patient, an 85-year-old male, where there was no evidence the physician had knowledge of any such propensities.[176] Because the hospital's liability was only derivative of the doctor's, the court affirmed the judgment for defendants.[177]

Thereafter, in *Eckhardt v. Charter Hospital of Albuquerque*, *Inc.*, a patient sued a hospital and therapist for damages based on an alleged sexual assault by the therapist and on alleged disclosure of confidential information to the patient's husband.[178] The trial court entered a judgment on the jury's verdict against the hospital, awarding the patient $132,000 on her claim of negligent selection and supervision, $70,000 on her claim of fraudulent misrepresentation, and $80,000 on her claim of negligent misrepresentation.[179] The New Mexico court of appeals affirmed, holding that substantial evidence supported the verdict on the negligent selection and supervision claims based on evidence that staff members knew of the therapist's past substance abuse problems and lack of clinical experience.[180]

New York

In *Bullock v. Parkchester General Hospital*, a nurse sued a doctor and hospital seeking to recover for injuries sustained when she was assaulted by a psychotic patient.[181] The trial court entered judgment for the plaintiff. In reversing that ruling on appeal, the Supreme Court of New York held the evidence on the duty to warn would not sustain findings against the defendants.[182] The court specifically noted that "the mere presence of a psychotic condition would not of itself indicate a tendency toward assault."[183] The court also held that "before liability may be imposed on either of the defendants it must be established that they *knew* that the patient's psychotic condition was such that an assault might be expected to follow."[184]

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[174] 387 P.2d 871, 872 (N.M. 1963).

[175] *Id*.

[176] *Id*.

[177] *Id*. at 874; *See also* Kelly v. Bd. of Trustees of Hillcrest Gen. Hosp., Inc., 529 P.2d 1233 (N.M. Ct. App. 1974) (reversing summary judgment for defendant hospital arising from assault and battery on plaintiff by her roommate in the hospital on grounds defendant failed to make prima facie showing it did not have actual knowledge that condition of roommate was such that assault and battery may be expected).

[178] 953 P.2d 722 (N.M. Ct. App. 1997).

[179] *Id*. at 725.

[180] *Id*. at 733.

[181] 160 N.Y.S.2d 117, 118 (N.Y. App. Div. 1957).

[182] *Id*. at 119.

[183] *Id.*

[184] *Id.* at 120 (emphasis in original).

Borrillo v. Beekman Downtown Hospital involved a patient's action against a hospital for injuries allegedly sustained after an attack by another patient.[185] The trial court granted the patient's motion to dispense with the convening of a medical malpractice panel.[186] In affirming that ruling on appeal, the Supreme Court of New York held the patient's action sounded in negligence, rather than medical malpractice. The court noted "the allegations of the complaint do not involve diagnosis, treatment, or the failure to follow a physician's instructions. Rather, the gravamen of the action concerns the alleged failure to exercise ordinary and reasonable care in safeguarding the patient."[187] In another case, the court noted that a hospital owes a general duty to take reasonable care to protect patients from injury and that the "degree of care [owed] is commensurate with a patient's capacity to provide for her own safety . . . ."[188]

Noto v. St. Vincent's Hospital and Medical Center of New York involved claims by a former hospital patient against her attending psychiatrist and hospital arising from sexual relations between herself and the psychiatrist after she was discharged and treatment ceased.[189] The trial court granted both defendants' motions to dismiss.[190] The Appellate Division of the Supreme Court affirmed, holding that the plaintiff had no cause of action against the physician for lack of informed consent, because a sexual liaison is neither a treatment nor diagnosis.[191] Nor could the hospital be held liable under a respondeat superior theory because the psychiatrist's acts were not within the scope of employment nor done in furtherance of the hospital's business.[192]

In *Judith M. v. Sisters of Charity Hospital*, the plaintiff claimed a hospital employee sexually abused her while she was a patient.[193] The patient sought to hold the hospital vicariously liable for the employee's actions and directly liable for negligent hiring, training, and supervision. The appellate court affirmed summary judgment in favor of the defendants. In doing so, the court noted that an employer may be liable for the actions of its employees "so long as the tortious conduct is generally foreseeable and a natural incident of the employ-

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[185] 537 N.Y.S.2d 219, 220 (N.Y. App. Div. 1989).

[186] *Id*.

[187] *Id*. at 220. *See also* Freeman v. St. Clare's Hosp. & Health Ctr., 548 N.Y.S.2d 686 (N.Y. App. Div. 1989) (affirming judgment in favor of patient in action against hospital for failure to protect patient from rape by other patient while in multiple restraints and unsupervised in emergency department on grounds hospital violated duty to protect patient from injury).

[188] *Freeman*, 548 N.Y.S.2d at 686.

[189] 559 N.Y.S.2d 510 (N.Y. App. Div. 1990).

[190] *Id*. at 510.

[191] *Id*. at 511.

[192] *Id*.

[193] 93 N.Y.2d 932 (N.Y. 1999).

ment."[194] Applying this principle, the court held that "[a]ssuming plaintiff's allegations of sexual abuse are true, it is clear that the employee here departed from his duties for solely personal motives unrelated to the furtherance of the Hospital's business."[195]

In *Rodriguez v. Terence Cardinal Cooke Health Care Center*, the Supreme Court of New York, Appellate Division, affirmed summary judgment for a defendant nursing home in a wrongful death and personal injury action filed after an assault on one resident by another resident.[196] The court noted there was insufficient evidence to support a finding that the facility had notice of the assailant's violent tendencies or deviated from the relevant industry standard of supervision.[197]

North Carolina

In *Burns v. Forsyth County Hospital Authority*, a patient and his wife brought suit against a hospital for physical injury, lost earnings, mental anguish, and loss of consortium after the patient was allegedly injured when a mental patient with whom he shared a room threw a chair at him.[198] The trial court entered a directed verdict for the hospital on most of the plaintiffs' claims. On appeal, the Court of Appeals of North Carolina affirmed, noting "[t]here is no evidence that defendant hospital could have foreseen plaintiff being hit by a chair . . . ."[199]

In *Johnson v. Amethyst Corp.*, the appellate court addressed a patient's action against an alcohol and drug rehabilitation hospital and clinical assistant employed at the facility based on claims the assistant engaged in improper sexual contact with the plaintiff while she was a patient at the facility.[200] The trial court dismissed plaintiff's malpractice claim against the assistant, but the court of appeal reversed, holding the trial court erred in refusing to submit this claim to the jury.[201] The court held that "[a] cause of action for medical malpractice may be initiated based on sexual advances by a health care professional."[202]

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[194] *Id*. at 933 (if employee "for purposes of his own departs from the line of his duty so that for the time being his acts constitute an abandonment of his service, the master is not liable").

[195] *Id*.

[196] 771 N.Y.S.2d 516, 516-17 (N.Y. App. Div. 2004).

[197] *Id*; *see also* N.X. v. Cabrini Med'l Ctr., 719 N.Y.S.2d 60 (N.Y. Sup. Ct. 2001) (sexual assault on patient by surgical resident was not within scope of resident's employment and could not form basis for vicarious liability of hospital and possibility of sexual assault by resident was too remote to be considered legally foreseeable).

[198] 344 S.E.2d 839 (N.C. Ct. App. 1986).

[199] *Id*. at 845.

[200] 463 S.E.2d 397, 399 (N.C. Ct. App. 1995).

[201] *Id*. at 401.

[202] *Id*; *see also* Massengill v. Duke Univ. Med'l Ctr., 515 S.E.2d 70, 71-72 (N.C. Ct. App. 1999) (affirming summary judgment for licensed physician's assistant on hospital patient's medical malpractice claim on grounds physician's assistant was not providing "professional services" to patient at time of alleged unlawful sexual act by physician's assistant upon patient).

More recently, *Blalock v. Department of Health and Human Services* addressed a Certified Nurse Assistant's (CNA) request for judicial review of a final decision of the Department of Health and Human Services to register a finding of substantiated allegations of misconduct by the CNA against a nursing home resident.[203] Affirming the Department's decision, the court held that substantial evidence supported a finding the CNA committed misconduct by verbally and physically abusing a nursing home resident.[204]

Ohio

In *Taylor v. Doctors Hospital (West)*, a patient sued a hospital for injuries sustained during an alleged sexual assault and sexual battery by an orderly employed by the hospital.[205] The plaintiff sought to hold the hospital liable on theories of respondeat superior and negligence.[206] On appeal, the Court of Appeals of Ohio affirmed the trial court's order directing a verdict in favor of the hospital on the respondeat superior claim and the judgment entered on a jury verdict in the hospital's favor on the negligence claim.[207] As to the respondeat superior claim, the court held the claim was properly withheld from the jury because there was insufficient evidence the orderly was working within the scope of his employment at the time of the alleged assault and battery.[208] According to the court, "[a]n intentional and willful attack committed by an agent or employee, to vent his own spleen or malevolence against the injured person, is a clear departure from his employment and his principal or employer is not responsible therefore . . . ."[209]

Oregon

Laurie v. Patton Home for the Friendless involved an action by a nursing home resident against a nursing home for personal injuries sustained when an intruder broke in and attacked the resident.[210] The trial court entered judgment in favor of the nursing home. In affirming that judgment on appeal, the Supreme Court of Oregon held the nursing facility did not have an absolute duty to protect its residents.[211] Thereafter, in *G.L. v. Kaiser Foundation Hospitals, Inc.*, the Court of Appeals of Oregon held a hospital could not be held liable for

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[203] 546 S.E.2d 177, 179-80 (N.C. Ct. App. 2001),

[204] *Id*. at 181.

[205] 486 N.E.2d 1249 (Ohio Ct. App. 1985).

[206] *Id*. at 1250.

[207] *Id*. at 1252.

[208] *Id*.

[209] *Id*; *see also* Parker v. Baldwin Manor Nursing Home, Inc., No. 47714, 1984 WL 5090, at *2 (Ohio Ct. App. June 21, 1984) (genuine issues of material fact existed as to whether resident who struck plaintiff resident with cane was "characteristically disruptive" and whether facility was aware or should have been aware of resident's violent/disruptive propensities").

[210] 516 P.2d 76 (Or. 1973).

[211] *Id*. at 78.

damages on grounds of strict liability or implied contract, absent a statute, where a former patient sued the hospital for damages suffered after a sexual assault by an employee of the hospital.[212]

South Carolina

In *Andrews v. United States*, the Court of Appeals for the Fourth Circuit analyzed claims by a patient and her husband against the United States under the Federal Tort Claims Act.[213] The plaintiffs' claims were for mental distress caused by the alleged medical malpractice of government employees when a therapist employed by the federal government convinced the patient that sexual intercourse with a physician's assistant was the best course of treatment.[214] The United States District Court for the District of South Carolina entered judgment for the plaintiffs. In affirming, the Fourth Circuit held that the physician's assistant's supervisor "clearly" acted within the scope of his government employment when he negligently failed to provide adequate supervision of the treatment program in which the physician's assistant seduced the patient.[215]

Texas

Both Texas state courts and the Fifth Circuit Court of Appeals have addressed the issue of a provider's liability for injuries caused by third-party criminal conduct. *Diversicare General Partner, Inc. v. Rubio*, for example, involved a nursing home resident's claim that she was sexually abused and sexually assaulted by another resident.[216] The Texas Supreme Court held the resident's claim amounted to a cause of action for departure from the accepted standard of care within the scope of the Medical Liability Insurance Improvement Act,[217] which requires plaintiffs to follow certain procedures when bringing medical malpractice claims.[218]

Bodin v. Vagshenian involved patients who claimed they were sexually assaulted during treatment with the Department of Veterans Affairs.[219] The plaintiffs sued under the Federal Tort Claims Act, alleging the federal government was liable for their treating psychiatrist's assault and malpractice and for other clinic employees' failure to prevent the assaults.[220]

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[212] 746 P.2d 731, 732 (Or. Ct. App. 1988).

[213] 732 F.2d 366, 367 (4th Cir. 1984).

[214] *Id*. at 368.

[215] *Id*. at 370.

[216] 185 S.W.3d 842, 845 (Tex. 2005).

[217] *Id*. at 848.

[218] *Id*. at 862.

[219] 462 F.3d 481, 483 (5th Cir. 2006).

[220] *Id*.

Following a bench trial, the United States District Court for the Western District of Texas granted judgment for the government based on lack of subject matter jurisdiction.[221] On appeal, the Fifth Circuit held the psychiatrist acted outside his scope of employment, thus precluding recovery on the respondeat superior claims.[222] The court also held that the intentional tort exception to the Federal Tort Claims Act's "scope of employment" immunity did not bar claims alleging other clinic employees failed to prevent the alleged assault.[223]

Washington

In another Federal Tort Claims Act case, *Simmons v. United States*, a patient sued the federal government for injuries sustained when her health service counselor wrongfully engaged in a sexual relationship with her.[224] The United States District Court for the Western District of Washington entered judgment in favor of the patient.[225] The Ninth Circuit Court of Appeals affirmed, holding the counselor was acting within the scope of his employment at the time of the sexual misconduct.[226]

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[221] *Id*.

[222] *Id*. at 486.

[223] *Id*.

[224] 805 F.2d 1363 (9th Cir. 1986).

[225] *Id*. at 1364.

[226] *Id*. at 1369.

Appendix B

Relevant ISO CGL Policy Provisions

I. Insuring Agreement

SECTION I—COVERAGES

COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY

1. Insuring Agreement

   a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages . . . .

      "Bodily Injury" means bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.

COVERAGE B PERSONAL AND ADVERTISING INJURY LIABILITY

1. Insuring Agreement

   a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "personal and advertising injury" to which this insurance applies.

   "Personal and advertising injury" means injury, including consequential "bodily injury", arising out of one or more of the following offenses:

   a. False arrest, detention or imprisonment;

   b. Malicious prosecution;

   c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor;

   d. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;

   e. Oral or written publication, in any manner, of material that violates a person's right of privacy;

   f. The use of another's advertising idea in your "advertisement"; or

   g. Infringing upon another's copyright, trade dress or slogan in your "advertisement".

II. Definition of "Insured"

SECTION II—WHO IS AN INSURED

1. If you are designated in the Declarations as:

   a. An individual, you and your spouse are insureds, but only with respect to the conduct of a business of which you are the sole owner.

   b. A partnership or joint venture, you are an insured. Your members, your partners, and their spouses are also insureds, but only with respect to the conduct of your business.

   c. A limited liability company, you are an insured. Your members are also insureds, but only with respect to the conduct of your business. Your managers are insureds, but only with respect to their duties as your managers.

   d. An organization other than a partnership, joint venture or limited liability company, you are an insured. Your "executive officers" and directors are insureds, but only with respect to their duties as your officers or directors. Your stockholders are also insureds, but only with respect to their liability as stockholders.

   e. A trust, you are an insured. Your trustees are also insureds, but only with respect to their duties as trustees.

2. Each of the following is also an insured:

   a. Your "volunteer workers" only while performing duties related to the conduct of your business, or your "employees", other than either your "executive officers" (if you are an organization other than a partnership, joint venture or limited liability company) or your managers (if you are a limited liability company), but only for acts within the scope of their employment by you or while performing duties related to the conduct of your business. However, none of these "employees" or "volunteer workers" are insureds for:

      (1) "Bodily injury" or "personal and advertising injury":

         (a) To you, to your partners or members (if you are a partnership or joint venture), to your members (if you are a limited liability company), to a "co- employee" while in the course of his or her employment or performing duties related to the conduct of your business, or to your other "volunteer workers" while performing duties related to the conduct of your business;

         (b) To the spouse, child, parent, brother or sister of that "co-employee" or "volunteer worker" as a consequence of Paragraph (1)(a) above;

(c) For which there is any obligation to share damages with or repay someone else who must pay damages because of the injury described in Paragraphs (1)(a) or (b) above; or

(d) Arising out of his or her providing or failing to provide professional health care services.

(2) "Property damage" to property:

(a) Owned, occupied or used by,

(b) Rented to, in the care, custody or control of, or over which physical control is being exercised for any purpose by you, any of your "employees", "volunteer workers", any partner or member (if you are a partnership or joint venture), or any member (if you are a limited liability company).

b. Any person (other than your "employee" or "volunteer worker"), or any organization while acting as your real estate manager.

"Volunteer worker" means a person who is not your "employee", and who donates his or her work and acts at the direction of and within the scope of duties determined by you, and is not paid a fee, salary or other compensation by you or anyone else for their work performed for you.

III. "Additional Insured" Endorsement

ADDITIONAL INSURED—MANAGERS OR LESSORS OF PREMISES

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

1. Designation of Premises (Part Leased to You):
2. Name of Person or Organization (Additional Insured):
3. Additional Premium:

(If no entry appears above, the information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule but only with respect to liability arising out of the ownership, maintenance or use of that part of the premises leased to you and shown in the Schedule and subject to the following additional exclusions:

This insurance does not apply to:

1. Any "occurrence" which takes place after you cease to be a tenant in that premises.
2. Structural alterations, new construction or demolition operations performed by or on behalf of the person or organization shown in the Schedule.

IV. Policy Conditions

A. *Timely Notice*

2. Duties In The Event Of Occurrence, Offense, Claim Or Suit

   a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:

      (1) How, when and where the "occurrence" or offense took place;

      (2) The names and addresses of any injured persons and witnesses; and

      (3) The nature and location of any injury or damage arising out of the "occurrence" or offense.

   b. If a claim is made or "suit" is brought against any insured, you must:

      (1) Immediately record the specifics of the claim or "suit" and the date received; and

      (2) Notify us as soon as practicable.

      You must see to it that we receive written notice of the claim or "suit" as soon as practicable.

   c. You and any other involved insured must:

      (1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or "suit";

      (2) Authorize us to obtain records and other information;

      (3) Cooperate with us in the investigation or settlement of the claim or defense against the "suit"; and

      (4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply.

   d. No insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

B. *Other Insurance*

4. Other Insurance

If other valid and collectible insurance is available to the insured for a loss we cover under Coverages A or B of this Coverage Part, our obligations are limited as follows:

a. Primary Insurance

This insurance is primary except when b. below applies. If this insurance is primary, our obligations are not affected unless any of the other insurance is also primary. Then, we will share with all that other insurance by the method described in c. below.

b. Excess Insurance

This insurance is excess over:

(1) Any of the other insurance, whether primary, excess, contingent or on any other basis:

(a) That is Fire, Extended Coverage, Builder's Risk, Installation Risk or similar coverage for "your work";

(b) That is Fire insurance for premises rented to you or temporarily occupied by you with permission of the owner;

(c) That is insurance purchased by you to cover your liability as a tenant for "property damage" to premises rented to you or temporarily occupied by you with permission of the owner; or

(d) If the loss arises out of the maintenance or use of aircraft, "autos" or watercraft to the extent not subject to Exclusion g. of Section I—Coverage A—Bodily Injury And Property Damage Liability.

(2) Any other primary insurance available to you covering liability for damages arising out of the premises or operations for which you have been added as an additional insured by attachment of an endorsement.

When this insurance is excess, we will have no duty under Coverages A or B to defend the insured against any "suit" if any other insurer has a duty to defend the insured against that "suit". If no other insurer defends, we will undertake to do so, but we will be entitled to the insured's rights against all those other insurers.

When this insurance is excess over other insurance, we will pay only our share of the amount of the loss, if any, that exceeds the sum of:

(1) The total amount that all such other insurance would pay for the loss in the absence of this insurance; and

(2) The total of all deductible and self-insured amounts under all that other insurance.

We will share the remaining loss, if any, with any other insurance that is not described in this Excess Insurance provision and was not bought specifically to apply in excess of the Limits of Insurance shown in the Declarations of this Coverage Part.

c. Method Of Sharing

If all of the other insurance permits contribution by equal shares, we will follow this method also. Under this approach each insurer contributes equal amounts until it has paid its applicable limit of insurance or none of the loss remains, whichever comes first.

If any of the other insurance does not permit contribution by equal shares, we will contribute by limits. Under this method, each insurer's share is based on the ratio of its applicable limit of insurance to the total applicable limits of insurance of all insurers.

C. *Contractual Liability*

b. Contractual Liability

"Bodily injury" or "property damage" for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages:

(1) That the insured would have in the absence of the contract or agreement; or

(2) Assumed in a contract or agreement that is an "insured contract", provided the "bodily injury" or "property damage" occurs subsequent to the execution of the contract or agreement. Solely for the purposes of liability assumed in an "insured contract", reasonable attorney fees and necessary litigation expenses incurred by or for a party other than an insured are deemed to be damages because of "bodily injury" or "property damage", provided:

(a) Liability to such party for, or for the cost of, that party's defense has also been assumed in the same "insured contract"; and

(b) Such attorney fees and litigation expenses are for defense of that party against a civil or alternative dispute resolution proceeding in which damages to which this insurance applies are alleged.

"Insured contract" is defined as:

a. A contract for a lease of premises. However, that portion of the contract for a lease of premises that indemnifies any person or organization for damage by fire

to premises while rented to you or temporarily occupied by you with permission of the owner is not an "insured contract";

b. A sidetrack agreement;

c. Any easement or license agreement, except in connection with construction or demolition operations on or within 50 feet of a railroad;

d. An obligation, as required by ordinance, to indemnify a municipality, except in connection with work for a municipality;

e. An elevator maintenance agreement;

f. That part of any other contract or agreement pertaining to your business (including an indemnification of a municipality in connection with work performed for a municipality) under which you assume the tort liability of another party to pay for "bodily injury" or "property damage" to a third person or organization. Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.

Paragraph f. does not include that part of any contract or agreement:

(1) That indemnifies a railroad for "bodily injury" or "property damage" arising out of construction or demolition operations, within 50 feet of any railroad property and affecting any railroad bridge or trestle, tracks, road-beds, tunnel, underpass or crossing;

(2) That indemnifies an architect, engineer or surveyor for injury or damage arising out of:

(a) Preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or

(b) Giving directions or instructions, or failing to give them, if that is the primary cause of the injury or damage; or

(3) Under which the insured, if an architect, engineer or surveyor, assumes liability for an injury or damage arising out of the insured's rendering or failure to render professional services, including those listed in (2) above and supervisory, inspection, architectural or engineering activities.

D. ***Supplementary Payments***

SUPPLEMENTARY PAYMENTS—COVERAGES A AND B

2. If we defend an insured against a "suit" and an indemnitee of the insured is also named as a party to the "suit", we will defend that indemnitee if all of the following conditions are met:

   a. The "suit" against the indemnitee seeks damages for which the insured has assumed the liability of the indemnitee in a contract or agreement that is an "insured contract";

   b. This insurance applies to such liability assumed by the insured;

   c. The obligation to defend, or the cost of the defense of, that indemnitee, has also been assumed by the insured in the same "insured contract";

   d. The allegations in the "suit" and the information we know about the "occurrence" are such that no conflict appears to exist between the interests of the insured and the interests of the indemnitee;

   e. The indemnitee and the insured ask us to conduct and control the defense of that indemnitee against such "suit" and agree that we can assign the same counsel to defend the insured and the indemnitee; and

   f. The indemnitee:

      (1) Agrees in writing to:

         (a) Cooperate with us in the investigation, settlement or defense of the "suit";

         (b) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the "suit";

         (c) Notify any other insurer whose coverage is available to the indemnitee; and

         (d) Cooperate with us with respect to coordinating other applicable insurance available to the indemnitee; and

      (2) Provides us with written authorization to:

         (a) Obtain records and other information related to the "suit"; and

         (b) Conduct and control the defense of the indemnitee in such "suit".

   So long as the above conditions are met, attorneys' fees incurred by us in the defense of that indemnitee, necessary litigation expenses incurred by us and necessary litigation expenses incurred by the indemnitee at our request will be paid as Supplementary Payments. Notwithstanding the provisions of Paragraph 2.b.(2) of

Section I—Coverage A—Bodily Injury And Property Damage Liability, such payments will not be deemed to be damages for "bodily injury" and "property damage" and will not reduce the limits of insurance.

Our obligation to defend an insured's indemnitee and to pay for attorneys' fees and necessary litigation expenses as Supplementary Payments ends when:

a. We have used up the applicable limit of insurance in the payment of judgments or settlements; or

b. The conditions set forth above, or the terms of the agreement described in Paragraph f. above, are no longer met.

V. Coverage Exclusions

A. *Bodily Injury and Property Damage Coverage*

This insurance does not apply to:

a. Expected Or Intended Injury

"Bodily injury" or "property damage" expected or intended from the standpoint of the insured. This exclusion does not apply to "bodily injury" resulting from the use of reasonable force to protect persons or property.

* * *

c. Liquor Liability

"Bodily injury" or "property damage" for which any insured may be held liable by reason of:

(1) Causing or contributing to the intoxication of any person;

(2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

(3) Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

This exclusion applies only if you are in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages.

B. ***Personal and Advertising Injury Coverage***

This insurance does not apply to:

a. Knowing Violation Of Rights Of Another

"Personal and advertising injury" caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict "personal and advertising injury".

* * *

d. Criminal Acts

"Personal and advertising injury" arising out of a criminal act committed by or at the direction of the insured.

C. ***Assault and Battery Exclusion for Specific Risks***

1. Exclusion a. of 2. Exclusions, COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY, SECTION I—COVERAGES, is replaced by:

   a. Expected Or Intended Injury, Or Assault Or Battery

   "Bodily injury" or "property damage":

   (1) Expected or intended from the standpoint of any insured; or

   (2) Arising out of assault or battery, or out of any act or omission in connection with the prevention or suppression of an assault or battery.

2. Exclusion z. is added to 2. Exclusions of COVERAGE B PERSONAL AND ADVERTISING INJURY LIABILITY, SECTION I—COVERAGES:

   This insurance does not apply to:

   z. Assault Or Battery

   "Personal and advertising injury" arising out of assault or battery, or out of any act or omission in connection with the prevention or suppression of an assault or battery.

Being Neighbourly: Canada Welcomes Foreign Defendants in Class Proceedings†

David T. Neave

Introduction

Although it appears there is a trend developing in United States courts to restrict and place limits on class actions, including class proceedings involving pharmaceutical and medical products, the same cannot be said with respect to courts in Canada. To the contrary, Canadian courts apply a broad approach to jurisdiction over foreign defendants named in pharmaceutical and medical products cases. Moreover, once named in a putative class action in Canada, a foreign defendant may be surprised by the relatively minimal criteria for certification of a class, the plaintiff's low evidentiary burden for establishing those criteria, and the broad scope of causes of action that can be certified.

Part I of this Article discusses Canada's general approach to jurisdictional issues. Part II provides an overview of certification requirements in Canada, including the evidentiary onus on the plaintiff, as recently confirmed by the Supreme Court of Canada. Part III considers some of the claims or causes of action that are available to Canadian plaintiffs that may not be available in other jurisdictions. Finally, Part IV canvasses some differences between the substantive law of the United States and Canada that are relevant to pharmaceutical and medical device class actions.

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I.
The Broad Approach to Jurisdiction

A. *The "Real and Substantial Connection" Test*

Canadian courts will take "territorial competence"[1] (formerly, jurisdiction *simpliciter*) over legal proceedings where there is a "real and substantial connection" between the subject matter of the dispute and the jurisdiction.[2] Canadian common law and legislation provide a number of presumptive connecting factors that link the subject matter of the litigation to the forum and establish this real and substantive connection. The following factors, when pleaded, satisfy this presumption of a real and substantial connection and, *prima facie,* entitle a court to assume jurisdiction over a dispute: [3]

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[1] *See, e.g.,* Court Jurisdiction and Proceedings Transfer Act (CJPTA), S.B.C. 2003, c. 28, s. 1 (Can.): "'[T]erritorial competence' means the aspects of a court's jurisdiction that depend on a connection between (a) the territory or legal system of the state in which the court is established, and (b) a party to a proceeding in the court or the facts on which the proceeding is based."

[2] Club Resorts Ltd. v. Van Breda, 2012 SCC 17, paras. 78-80 (Can.).

[3] *Id.* at para. 90.

(a) the defendant is domiciled or resident in the province;

(b) the defendant carries on business in the province;

(c) the tort was committed in the province; and

(d) a contract connected with the dispute was made in the province. [4]

Another presumptive connecting factor is when a claim for restitutionary obligations arises in the province.[5]

Although the presumption of territorial competence is subject to rebuttal by evidence, the presumption is likely to be determinative in most cases. Even if a court finds it has territorial competence, however, it still has the discretion to decline to exercise that competence on a finding of *forum non conveniens,* i.e., that there is a more appropriate forum to hear the proceeding.[6] The onus is always on the party asserting that the court should not exercise its jurisdiction.[7]

B. *A Trilogy of Recent Cases Applying the Test*

The "real and substantial connection" test affords Canadian courts broad territorial competence over disputes concerning events or parties within their jurisdiction. Although the determination whether there is real and substantial connection giving rise to territorial competence will always be fact specific, three recent decisions—*Stanway v. Wyeth Canada Inc*.,[8] *Fairhurst v. De Beers Canada Inc*.,[9] and *Kaynes v. BP, plc*.[10]—provide guidance as to the types of cases in which jurisdiction may be found.

1. *Stanway v. Wyeth Canada Inc.*

Stanway v. Wyeth Canada Inc.[11] is a relatively extreme example of a Canadian court exercising its broad approach to jurisdiction. In *Stanway*, the plaintiff commenced an action on behalf of residents of British Columbia who were diagnosed with breast cancer after taking progestin in combination with the defendants' hormone therapy drugs Premarin and Premplus.[12] The defendants included Wyeth, a public company incorporated in Delaware;

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4 *Id*.

5 *See* CJPTA, *supra* note 1, s. 10.

6 *Club Resorts*, 2012 SCC 17, at para. 102.

7 *Id*. at para. 103.

8 2009 BCCA 592 (Can.).

9 2012 BCCA 257 (Can.).

10 2013 ONSC 5802 (Can.).

11 2009 BCCA 592.

12 *Id.* at paras. 27-28.

Wyeth Canada; and certain Canadian and U.S. wholly-owned subsidiaries of Wyeth. The U.S. defendants brought an application asserting there was no real and substantial connection between British Columbia and the facts upon which the proceeding against the U.S. defendants was based and, thus, that the court did not have territorial competence to entertain the action against them.[13] According to these defendants, they did not "market Premarin or Premplus in Canada or put them into the Canadian market"; did not "test, market, label, distribute, promote or sell these products" to consumers in British Columbia or elsewhere in Canada; and never solicited, offered, advertised, or promoted goods and services to consumers in British Columbia or elsewhere in Canada.[14] They presented evidence that they never:

- maintained an office in British Columbia;
- had any offices or employees located in British Columbia;
- had any manufacturing or distribution facilities in British Columbia;
- maintained any bank accounts in British Columbia;
- had a mailing address or telephone listing in British Columbia; or
- held any notices of compliance from the Health Protection Branch of Health Canada to manufacture, distribute, or sell any pharmaceutical products in Canada.[15]

They also asserted that they were never registered or licensed to conduct business in British Columbia and were not required to, and did not, pay any sales, property, or other taxes in British Columbia.[16]

In denying the appeal from the British Columbia Supreme Court on the question of jurisdiction, the Court of Appeal of British Columbia applied the real and substantial test set out in section 10 of the Court Jurisdiction and Proceedings Transfer Act[17] and held that sections 10(g) and (h) were satisfied on the plaintiff's pleading.[18] Specifically, there was a presumed real and substantial connection with British Columbia and the facts on which the claims against defendants were based on the basis that the proceeding concerned torts committed in British Columbia;[19] and the plea that the defendants jointly marketed, tested, manufactured, labeled, distributed, promoted, sold, and otherwise placed the products

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[13] *Id*. at para. 1.

[14] *Id.* at para. 45.

[15] *Id*. at para. 37.

[16] *Id*.

[17] S.B.C. 2003, c. 28 (Can.)

[18] 2009 BCCA 592, paras. 62-63.

[19] *Id.* at para. 62.

into the stream of commerce in British Columbia was in effect a plea that the defendants, including the U.S. defendants, carried on business in British Columbia.[20] Moreover, the U.S. defendants admitted engaging in "'harmonization' and 'coordination' of matters involving core [product] monograph and labelling requirements, the efficacy of the products, and the collecting and sharing of other clinical research or trial information' with the Canadian defendants."[21] These bare facts, unrebutted, were sufficient to establish that the court had territorial competence to hear the action:

> The plea that the US defendants were parties to torts committed in British Columbia presumptively establishes direct and significant connections between British Columbia and the facts on which the proceeding against the US defendants is based. In other words, it establishes a sufficient real and substantial connection to clothe the British Columbia Supreme Court with jurisdiction over the US defendants.[22]

Accordingly, the chambers judge did not err in concluding the exercise of jurisdiction was proper.[23]

2. *Fairhurst v. De Beers Canada Inc.*

Fairhurst v. De Beers Canada Inc.[24] arose out of alleged international price fixing in circumstances where the end product was available for purchase in Canada. The plaintiff commenced a class proceeding in which Ms. Fairhurst, on behalf of herself and a class of residents, alleged that over a ten-year period the defendants conspired to fix the prices of gem grade diamonds contrary to the Competition Act[25] and the common law.[26] Six of the defendants—De Beers Investments, Inc., De Beers S.A., De Beers Consolidated Mines, Ltd., The Diamond Trading Company Limited, De Beers Centenary A.G., and CSO Valuations A.G.—*had no presence* in British Columbia or elsewhere in Canada and were not involved in any commercial operations in Canada.[27] These defendants challenged the jurisdiction of the British Columbia courts. In dismissing the defendants' application, the British Columbia Supreme Court applied the real and substantial test set out in section 10 of the CJPTA and, in light of the conspiracy allegations, held that the defendants had not rebutted the presumption of jurisdiction that arose on the basis of a pleaded allegation that

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[20] *Id.* at para. 63.

[21] *Id*. at para. 70.

[22] *Id.* at para. 69.

[23] In so holding, the court criticized the approach taken by the chambers judge as going further than necessary to resolve the question of jurisdiction. *Id.* at paras. 4, 71-73.

[24] 2012 BCCA 257 (Can).

[25] R.S.C. 1985, c. C.-34 (Can.).

[26] 2012 BCCA 257, para. 1.

[27] *Id.* at para. 6.

a tort and a restitutionary obligation arose in British Columbia.[28] The British Columbia Court of Appeal dismissed the appeal on the basis that the presumption of jurisdiction had not been rebutted.[29]

3. *Kaynes v. BP, plc*

In 2005, amendments to the Ontario Securities Act[30] established a civil cause of action against issuers, their directors and officers, and other defendants for misrepresentations affecting the price of securities on secondary markets ("Part XXIII.1"). Like the preexisting statutory cause of action for misrepresentations on the primary market, Part XXIII.1 permits recovery for damages without the need to demonstrate reliance on the misrepresentation.[31]

In *Kaynes v. BP, plc*, the plaintiff claimed that BP, a U.K. incorporated company, made misrepresentations and omissions in investor documents about its operational and safety programs "before and after the Deepwater Horizon oil spill in the Gulf of Mexico in April 2010."[32] The plaintiff alleged that "these misrepresentations had the effect of artificially inflating BP's share prices [and] that once the truth came out about BP's ability to respond to the [o]il [s]pill, the share prices dropped."[33] The plaintiffs advanced both a statutory claim for secondary market misrepresentation under Part XXIII.1 and a claim for common law negligent misrepresentation. The plaintiff himself did not purchase any BP securities in Canada; rather, he purchased only American Depository Shares (ADS) on the New York Stock Exchange (NYSE).[34] However, the proposed class included all Canadians who purchased common shares and ADS, whether on the Toronto Stock Exchange (TSX), NYSE, or European exchanges.[35]

BP brought a preliminary jurisdiction motion seeking a stay on the ground that the Ontario court did not have jurisdiction over the dispute or, alternatively, on the basis of *forum non conveniens*. It supported the motion with evidence that its principal offices are located in London, England; it owns no real or personal property in Canada; it has no offices or employees in Canada; it has several indirect Canadian subsidiaries that conduct exploration and development of energy properties in Canada; and its equity securities consist of common shares listed on the London and Frankfurt Stock Exchanges and of ADS listed (after 2008) only on the NYSE.[36]

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[28] *Id*. at para. 45.

[29] *Id*.

[30] R.S.O. 1990, c. s. 5 (Can.).

[31] Kaynes v. BP, plc, 2013 ONSC 5802, para 34 (Can.).

[32] *Id.* at paras. 1, 3, 8.

[33] *Id*. at para. 8.

[34] *Id*. at para. 7.

[35] *Id.* at para. 10.

[36] *Id*. at paras. 3-5.

BP argued that even if the statutory claim could be regarded as a tort committed in Ontario, that claim could not relate to the limited purchases that were made on the TSX.[37] The Ontario Superior Court of Justice dismissed the application on the basis that the statutory claim itself was tantamount to a tort, noting there was nothing in the Ontario Securities Act that restricted secondary market claims to investors who purchased shares on an *Ontario* exchange.[38] Accordingly, the court held it had jurisdiction.[39]

* * *

As seen in the above cases, Canadian courts will take a broad approach to the question of jurisdiction in class actions. Based on existing case law, it is likely that a Canadian court will accept jurisdiction in a class proceeding against a foreign defendant based on mere allegations that the defendant is alleged to have manufactured a defective product or a recalled product that was in the stream of commerce and then sold in Canada; *or* engaged in a misrepresentation or deceptive act or practice with respect to the product that was in the stream of commerce and then sold in Canada; *or* engaged in anticompetitive conduct, including price fixing, where the product in issue was in the stream of commerce and then sold in Canada. A court is also likely to accept jurisdiction where the defendant is a public company alleged to have made public secondary market misrepresentations and a Canadian purchases securities in that company based on the alleged misrepresentation, regardless of where the securities were purchased.

Whether and to what extent courts in other jurisdictions will continue to apply the connecting factors expansively, as did these courts, remains to be seen. If they do, however, then these categories are likely to expand significantly in the future.

II.
Overview of Certification Requirements

A. *The Certification Criteria*

In Canada, class action legislation has been enacted in each province, except for Prince Edward Island and the three territories (Yukon, Northwest Territories, and Nunavut).[40] Even in the jurisdictions without specific legislation, class proceedings are permitted under their

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[37] *Id*. at para. 30.

[38] *Id*. at para. 33.

[39] In so holding, the *Kaynes* court followed the Ontario Court of Appeal's decision in *Abdula v. Canadian Solar Inc*., 2012 ONCA 211 (Can.), in which the court took jurisdiction in a proposed securities class action with respect to alleged misrepresentations said to have affected the price of Canadian Solar's securities on the secondary markets. Canadian Solar was not a reporting issuer in Ontario, and its shares were traded only on the NASDAQ and not on a Canadian exchange.

[40] Mark L. Berenblut, Bradley A. Heys, & Svetlana Starykh, *Trends in Canadian Securities Class Actions: 1997-2008*, NERA Economic Consulting 1 n. 2, (Jan. 2009), *available at* http://www.nera.com/content/dam/nera/publications/archive1/Recent_Trends_Canada_0109.pdf.

respective Rules of Court. In addition, there are Federal Court of Canada Rules that provide for class proceedings in federal court with respect to specific subject matters. However, most class proceedings are brought in the provincial courts.

Although the class action legislation varies somewhat from province to province,[41] generally a plaintiff must satisfy five criteria in order for the court to certify the action as a class proceeding: (1) the pleading must disclose a *cause of action*; (2) there must be an *identifiable class* of two or more persons; (3) the claims of the class members must raise issues against the defendants that are *common to all class members*; (4) the class proceeding must be the *preferable procedure* for the fair and efficient resolution of the common issues; and (5) there must be a *representative plaintiff* who would fairly and adequately represent the interests of the class and who does not have a conflicting interest with other class members.[42] Once these criteria are satisfied, the court must certify the proceeding as a class proceeding.

Certain provinces permit class proceedings to be brought on behalf of a national class of persons on an "opt-out" basis; that is, persons falling within the class definition are class members and bound by all decisions unless they take the required steps to opt out of the proceeding. Other provinces require that extra-provincial residents take positive action to opt into a class proceeding before they may become members of the class.

As these criteria demonstrate, the threshold for certifying a proposed class proceeding in Canada is lower than in the United States.[43] There is no numerosity or typicality requirement.[44] Notably, a class proceeding need only be the preferable procedure for resolving the common issues (not all aspects of the controversy), and the common issues need not predominate over the individual issues.

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[41] In Québec, the term for certification is "authorization." The requirements for authorization are set out in Article 1003 of the Québec Code of Civil Procedure, R.S.Q., c. C-25 (Can.). Although similar to the certification requirements, the authorization process is generally considered more favorable to plaintiffs than in the other provinces. Class actions are "authorized" if: (a) the claims of the proposed class members raise identical, similar or related questions of fact or law; (b) the facts alleged seem to justify the conclusions sought; (c) the composition of the proposed class makes it impractical to proceed through representative actions or by joinder of actions (the underlying question is whether it is appropriate to proceed by way of a class proceeding); and (d) the proposed representative class member is in a position to represent the putative class members adequately. *Id*. Furthermore, when certifying a class, the court must assess whether the proceedings comply with the proportionality and reasonability requirements applicable to all types of actions under the Code of Civil Procedure. *Id*. art. 4.2. In Québec, the proposed representative plaintiff is not required to file an affidavit in support of his or her application; to the contrary, no evidence can be adduced on the motion for authorization without leave of court. *Id*. art. 1002.

[42] *See. e.g.,* Class Proceedings Act, R.S.B.C. 1996, c. 50, s. 4.

[43] In the United States, Federal Rule of Civil Procedure 23(a) requires "(1) the class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class."

[44] *See supra* note 42.

B. *The Standard of Proof for Certification*

1. The Test: "Some Basis In Fact"

In the common law provinces in Canada, in order for the proceeding to be certified as a class proceeding, the plaintiff must satisfy each of the five criteria listed above. However, the standard on which the certification criteria are assessed is very low. This is in part because there is no pre-certification document production and no discoveries or depositions are conducted before the certification application is heard. In Canada, unlike in the U.S., the court will not engage in a robust analysis of the merits of the case at the certification stage.[45] Indeed, recent attempts to inject a merits analysis into class action litigation in Canada have been soundly rejected by the Supreme Court of Canada. For example, in *Pro-Sys Consultants Ltd. v. Microsoft Corp.*,[46] one of three class action decisions the Supreme Court of Canada issued on October 31, 2013, Justice Rothstein stated:

> I would note that Canadian courts have resisted the U.S. approach of engaging in a robust analysis of the merits at the certification stage. Consequently, the outcome of a certification application will not be predictive of the success of the action at the trial of the common issues. I think it important to emphasize that the Canadian approach at the certification stage does not allow for an extensive assessment of the complexities and challenges that a plaintiff may face in establishing its case at trial. After an action has been certified, additional information may come to light calling into question whether the requirements of s. 4(1) continue to be met. It is for this reason that enshrined in the CPA is the power of the court to decertify the action if at any time it is found that the conditions for certification are no longer met (s. 10(1)).[47]

When assessing the first certification criterion—that the pleadings disclose a cause of action—the court accepts as true the factual assertions in the pleading and assesses the legal basis for the claim on a "plain and obvious" standard; i.e., is it plain and obvious that the plaintiff's claim cannot succeed?[48]

In order to satisfy the remaining four criteria, the plaintiff must provide evidence to demonstrate that there is "some basis in fact" to "satisfy the applications judge that the conditions for certification have been met to a degree that should allow the matter to proceed on a class basis without foundering at the merits stage by reason of the requirements [for certification] not having been met."[49] As Justice Rothstein observed in *Pro-Sys*:

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[45] *Compare, e.g., In re Hydrogen Peroxide Antitrust Litig.*, 552 F.3d 305 (3d Cir. 2008).

[46] 2013 SCC 57 (Can.).

[47] *Id*. at para. 105.

[48] *Id*. at para 63.

[49] *Id*. at para. 104.

> The "some basis in fact" standard does not require that the court resolve conflicting facts and evidence at the certification stage. Rather, it reflects the fact that at the certification stage "the court is ill-equipped to resolve conflicts in the evidence or to engage in the finely calibrated assessments of evidentiary weight." The certification stage does not involve an assessment of the merits of the claim and is not intended to be a pronouncement on the viability or strength of the action; "rather, it focuses on the form of the action in order to determine whether the action can appropriately go forward as a class proceeding."
>
> Nevertheless, it is worth reaffirming the importance of certification as a meaningful screening device. The standard for assessing evidence at certification does not give rise to "a determination of the merits of the proceeding"; nor does it involve such a superficial level of analysis into the sufficiency of the evidence that it would amount to nothing more than symbolic scrutiny.[50]

In Québec, the standard is somewhat different. At the authorization stage the issue is whether the allegations support the conclusions *prima facie* or whether there is a disclosure of a "colour of right." The burden is one of demonstration and not of proof.[51]

2. Assessing Expert Evidence Submitted in Support of the Certification Criteria

Expert evidence is frequently filed to satisfy the commonality requirement, particularly in an attempt to show that the fact of harm and the amount of damages can be established on a classwide basis. In *Pro-Sys*, the Supreme Court of Canada clarified the standard for assessing such evidence. According to Justice Rothstein:

> [T]he expert methodology must be sufficiently credible or plausible to establish some basis in fact for the commonality requirement. This means that the methodology must offer a realistic prospect of establishing loss on a class-wide basis so that, if the [alleged wrongdoing] is eventually established at the trial of the common issues, there is a means by which to demonstrate that it is common to the class . . . . The methodology cannot be purely theoretical or hypothetical, but must be grounded in the facts of the particular case in question. There must be some evidence of the availability of the data to which the methodology is to be applied. . . . However, resolving conflicts between the experts is an issue for the trial judge and not one that should be engaged in at certification . . . .[52]

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[50] *Id*. at paras. 102-03 (citations omitted).

[51] Infineon Techs. AG v. Option Consommateurs, 2013 SCC 59, paras. 61-62 (Can.).

[52] 2013 SCC 57, paras. 118, 126 (Can.) (citations omitted).

In other words, the evidence must meet the threshold admissibility requirements for opinion evidence, and the court may consider some *Daubert*-type factors in determining admissibility. However, even when expert evidence is admissible, the court may not engage in detailed assessment of the evidence. Thus, on a certification application, a Canadian court will not weigh affidavit evidence, including conflicting expert evidence, that the parties may file with respect to the certification criteria.

III.
A Broad Range of Claims Is Available in Canada

Not only are the requirements for class certification relaxed in Canada as compared to other jurisdictions, the courts have certified class actions in a wider range of claims than may be typical elsewhere. Some examples follow.

A. *Indirect Purchasers*

In three recent decisions heard together—*Pro-Sys Consultants Ltd. v. Microsoft Corp.*,[53] *Sun-Rype Products Ltd. v. Archer Daniels Midland Co.*,[54] and *Infineon Technologies AG v. Option Consommateurs*[55]—the Supreme Court of Canada considered whether indirect purchasers may bring a class action to recover losses passed on to them by the direct purchaser for products for which the direct purchaser was allegedly overcharged by the manufacturer. In each, the Court concluded that the issue was appropriate for class treatment.[56]

In *Pro-Sys,* the lead case, Justice Rothstein described the indirect purchaser issue in the following terms:

> [I]ndirect purchasers are consumers who have not purchased a product directly from the alleged overcharger, but who have purchased it either from one of the overcharger's direct purchasers, or from some other intermediary in the chain of distribution. The issue is whether indirect purchasers have a cause of action against the party who has effectuated the overcharge at the top of the distribution chain that has allegedly injured them indirectly as the result of the overcharge being "passed on" down the chain to them.[57]

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[53] 2013 SCC 57 (Can.).

[54] 2013 SCC 58 (Can.).

[55] 2013 SCC 59 (Can.).

[56] *See Pro-Sys*, 2013 SCC 57, para. 142; *Sun-Rype*, 2013 SCC 58, para. 51 (but declining class certification based on the absence of an identifiable class; *id.* at paras. 61, 77-80); *Infineon*, 2013 SCC 59, para. 69.

[57] 2013 SCC 57, para. 16.

Rejecting the contrary rule adopted by federal courts in the United States,[58] the Supreme Court of Canada held that indirect purchasers are entitled to state a cause of action based on allegations that losses suffered by direct purchasers in an antitrust case have been passed on to them.[59] Thus, both indirect and direct purchasers in Canada can assert claims against both Canadian and foreign defendants in the same antitrust action, including those in which price-fixing allegations are advanced.

In allowing the claim, the Court acknowledged that, under Canadian law, a passing-on *defence* is "unavailable as a matter of restitution law."[60] Nonetheless, the Court held, "it does not follow" that indirect purchasers should be foreclosed from asserting a passing-on *claim*.[61] The Court summarized its analysis as follows:

> (1) The risks of multiple recovery and the concerns of complexity and remoteness are insufficient bases for precluding indirect purchasers from bringing actions against the defendants responsible for overcharges that may have been passed on to them.
>
> (2) The deterrence function of the competition law in Canada is not likely to be impaired by indirect purchaser actions.
>
> (3) While the passing-on defence is contrary to basic restitutionary principles, those same principles are promoted by allowing passing on to be used offensively.
>
> (4) Although the rule in *Illinois Brick* [*Co. v. Illinois*[62]] remains good law at the federal level in the United States, its subsequent repeal at the state level in many jurisdictions and the report to Congress recommending its reversal demonstrate that its rationale is under question.
>
> (5) Despite some initial support, the recent doctrinal commentary favours overturning the rule in *Illinois Brick*.[63]

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[58] *See* Hanover Shoe v. United Shoe Machinery Corp., 392 U.S. 481 (1968) (holding that indirect purchasers have no cause of action against overcharger); Illinois Brick Co. v. Illinois, 431 U.S. 720 (1977) (same).

[59] *Pro-Sys*, 2013 SCC 57, paras. 43-45.

[60] *Id.* at para. 60. The "passing on defence" is typically asserted by the manufacturer (or other entity responsible for the overcharge) against claims by the direct purchaser. According to the defence, if the direct purchaser passes the overcharge on to those to whom it sells the product, it has sustained no damage as a result of the overcharge and has no claim against the overcharger. *See id*. at para 18.

[61] *Id.* at para. 60.

[62] 431 U.S. 720 (1977); *see supra* note 58.

[63] *Pro-Sys*, 2013 SCC 57, para. 60.

With respect to the issue of double recovery, the Court was of the view that this concern could be managed by the trial courts. Again according to Justice Rothstein:

> This concern cannot be lightly dismissed. However, in my view, there are countervailing arguments to be considered. Practically, the risk of duplicate or multiple recoveries can be managed by the courts. Brennan J., dissenting in *Illinois Brick,* indicated that the risk of overlapping recovery exists only where additional suits are filed after an award for damages has been made or where actions by direct and indirect purchasers are pending at the same time. In both cases, he said, the risk is remote. . . .
>
> As for the risk of double recovery where actions by direct and indirect purchasers are pending at the same time, it will be open to the defendant to bring evidence of this risk before the trial judge and ask the trial judge to modify any award of damages accordingly. . . .
>
> Likewise, if the defendant presents evidence of parallel suits pending in other jurisdictions that would have the potential to result in multiple recovery, the judge may deny the claim or modify the damage award in accordance with an award sought or granted in the other jurisdiction in order to prevent overlapping recovery.[64]

Based on these recent rulings, and the relative ease with such claims can be asserted, it is reasonable to predict that the number of direct and indirect purchaser class actions will increase significantly in the coming years.

B. *Waiver of Tort*

"Waiver of tort" describes the circumstance in which a plaintiff "gives up the right to sue in tort and elects instead to base its claim in restitution, 'thereby seeking to recoup the benefits that the defendant has derived from the tortious conduct.'"[65] Stated differently, "it is a restitutionary doctrine that permits a plaintiff to recover benefits a defendant has obtained by its wrongdoing instead of damages measured by the plaintiff's loss."[66]

Waiver of tort is often pleaded in class proceedings brought in common law jurisdictions against pharmaceutical companies and medical products manufacturers. It is advanced in two ways. First, it may be pleaded as a stand-alone cause of action on the basis that the defendant has committed a "wrong" that has resulted in a gain to the defendant. Second, it may be pleaded as a remedy, in which case it is regarded as "parasitic"; i.e., if

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[64] *Id.* at paras. 37-41 (citations omitted).

[65] *Id.* at para. 93.

[66] Koubi v. Mazda Canada Inc., 2012 BCCA 310, para. 16 (Can.), *leave to appeal refused*, [2013] S.C.R. vii (Can.).

the plaintiff proves the underlying tort, he or she may "elect" to pursue the restitutionary remedy instead of damages. Whether waiver of tort is an independent cause of action, a remedy, or both, has been debated for years in Canadian, United States, and United Kingdom jurisprudence.[67]

As a result of the Supreme Court of Canada's recent decisions in *Pro-Sys, Sun-Rype,* and *Infineon*, that debate will continue. In *Pro-Sys*, Justice Rothstein framed the issues and the debate as follows:

> Causes of action in tort and restitution are not mutually exclusive, but rather provide alternative remedies that may be pursued concurrently. Waiver of tort is based on the theory that "in certain situations, where a tort has been committed, it may be to the plaintiff's advantage to seek recovery of an unjust enrichment accruing to the defendant rather than normal tort damages." An action in waiver of tort is considered by some to offer the plaintiff an advantage in that it may relieve them of the need to prove loss in tort, or in fact at all. . . .
>
> The U.S. and U.K. jurisprudence as well as the academic texts on the subject have largely rejected the requirement that the underlying tort must be established in order for a claim in waiver of tort to succeed. Another line of cases would find a cause of action in waiver of tort to be unavailable unless it can be established that the defendant has committed the underlying tort giving rise to the cause of action. At least one of these cases suggests that a reluctance to eliminate the requirement of proving loss as an element of the cause of action is part of the reason for requiring the establishment of the underlying tort. . . .
>
> In my view, this appeal is not the proper place to resolve the details of the law of waiver of tort, nor the particular circumstances in which it can be pleaded. I cannot say that it is plain and obvious that a cause of action in waiver of tort would not succeed.[68]

The Court's determination that it is not plain and obvious that a cause of action in waiver of tort would not succeed is of concern to defendants in Canadian class action cases for at least two important reasons. First, other than the requirement of wrongful conduct, the elements of "waiver of tort" have not been defined or enumerated. Second, given the Court's approach, the mere pleading of waiver of tort as an independent cause of action may be sufficient to satisfy the cause of action criterion for certification.

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[67] *See, e.g.,* Andersen v. St. Jude Med., Inc., 2012 ONSC 3660, para. 578 *ff.* (Can.) (addressing the debate in Canadian courts).

[68] 2013 SCC 57, paras. 93-97 (citations omitted).

The recent decision in *Koubi v. Mazda Canada Inc*.[69] may give some guidance as to the scope of the "wrongful conduct" needed to support a cause of action in waiver of tort. In *Koubi*, the British Columbia Court of Appeal held that the alleged statutory breach of the British Columbia Business Practices and Consumer Protection Act[70] could not provide the requisite wrongful conduct as the Code was "exhaustive" and provided express statutory causes of action and remedies.[71] It remains to be seen whether the argument that a statutory scheme is complete or exhaustive will be applied in the context of federal legislation, such as the Competition Act, or with respect to consumer protection statutes in the other provinces.

Notably, in analyzing the issue in *Koubi*, the court concluded it *was* appropriate to consider at the certification stage whether it was "plain and obvious" that the waiver of tort cause of action could not succeed, because resolution of the issue was not dependent on a trial with a full factual record.[72] In support, the court cited the observation of the Ontario Superior Court in *Andersen v. St. Jude Medical, Inc.*,[73] that a full factual record after a common issues trial did not assist to illuminate the legal issues surrounding waiver of tort. The *Andersen* decision followed a 140-day common issues trial in Ontario with respect to Silzone mechanical heart valves.[74] Justice Lax addressed the controversy regarding waiver of tort and noted that it was time to decide if waiver of tort was an independent cause of action or a remedy.[75] Justice Lax disagreed with the line of cases that had previously concluded that a full evidentiary record was required to answer the question:

> Given the philosophical and policy considerations mentioned above, it is my view that the fundamental question for a court to answer is whether the recognition (or not) of the waiver of tort doctrine is within the capacity of a court to resolve, or whether it has such far-reaching and complex effects that it is best left to consideration by the Legislature. On the basis of my experience, the answer to this and the other questions surrounding the waiver of tort doctrine is not dependent on a trial with a full factual record and may require no evidence at all.[76]

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[69] 2012 BCCA 310 (Can.), *leave to appeal refused*, [2013] S.C.R. vii (Can.).

[70] R.S.B.C. 2004, c. 2 (Can.).

[71] 2012 BCCA 310, para. 63. The court separately held that the plaintiff's claim under the British Columbia Sale of Goods Act, R.S.B.C. 1996, c. 410 (Can.), was barred because it was contrary to the express intent of the legislature. 2012 BCCA 310, para. 72.

[72] *Id.* at para. 81.

[73] 2012 ONSC 3660 (Can.).

[74] *Id*. at para. 1.

[75] *See id*. at paras. 578-93.

[76] *Id*. at para. 584.

Given the uncertainties surrounding the scope of the waiver of tort doctrine, and the Supreme Court of Canada's willingness in *Pro-Sys* to allow such a cause of action to proceed, it is all but certain that plaintiffs in class proceedings will continue to advance waiver of tort claims as the predicate cause of action for certification.

C. *Privacy Class Actions*

The relatively recent Ontario Court of Appeal decision in *Jones v. Tsige*[77] confirmed the existence of a common law tort of invasion of privacy—"intrusion upon seclusion." This tort, newly recognized in Ontario, is based in part on the Restatement (Second) of Torts and requires that (1) the defendant's conduct was intentional or reckless; (2) the defendant invaded the plaintiff's private affairs or concerns without lawful justification; and (3) a reasonable person would regard the invasion as highly offensive, causing distress, humiliation, or anguish.[78] The plaintiff need not prove any harm to his or her economic interests,[79] nor is it necessary that plaintiff's personal information be published or disseminated.[80] Although some provinces had enacted statutes making a violation of privacy actionable in similar circumstances even prior to *Jones*,[81] these statutory provisions had not been used to advance class action claims.

Given that some drug and medical device manufacturers collect and use highly personal information, including personal health information, in their ordinary activities, (e.g., in the course of implant registration or adverse event tracking), plaintiffs' lawyers may now seek to initiate class actions based on the new tort of intrusion upon seclusion. The lack of a requirement to prove loss may be attractive to class counsel. Although no privacy class action has yet been commenced against a drug or medical device manufacturer, such class actions have been initiated against companies in other industries. Therefore, it is likely only a matter of time before such actions find their way into the pharmaceutical and medical arena.

IV.
Some Differences Between U.S. and Canadian Substantive Law Relevant to Class Actions

In contrast to the relative ease of obtaining class certification in Canada, there are a number of important differences in Canadian and U.S. substantive law that may make class proceedings less available or at least less desirable than in the U.S. These include important limitations on certain substantive claims and on the scope of recoverable damages.

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77 2012 ONCA 32 (Can.).

78 *Id*. at para 71.

79 *Id*.

80 *See id*. at para. 57.

81 *See*, *e.g.*, Privacy Act, R.S.B.C. 1996, c. 373, s. 1 (Can.).

A. *Canadian Law Does Not Recognize Claims for Pure Economic Damages Resulting from Non-Dangerous Products*

In August 2012, the Ontario Superior Court of Justice dismissed the plaintiffs' class certification motion in *Arora v. Whirlpool Canada LP*[82] on the basis, in part, that there can be no recovery in a product liability negligence action for pure economic losses against the manufacturer of an allegedly defective but non-dangerous consumer product. In reasons for judgment released October 31, 2013, the Court of Appeal upheld the motion judge's decision, and clarified the law relating to liability for non-dangerous goods.[83]

The proposed class in *Arora* consisted of persons who owned front-loading washing machines manufactured by the defendants between 2001 and 2008.[84] The plaintiffs alleged that the washing machines suffered from a design defect that led to the buildup of mould, mildew, and bacteria ("biofilm") and resulted in an unpleasant odor.[85] The pleadings alleged that biofilm buildup led to a variety of health problems as a result of exposure to "toxins and allergens."[86] However, the plaintiffs did not allege that the defect was dangerous; rather, they claimed the defendants were liable in negligence for the class members' pure economic losses.[87] According to the motion judge, under *Winnipeg Condominium Corp. No. 36 v. Bird Construction Co.*[88] and subsequent authorities, "there is no product-liability negligence action for pure economic loss against a manufacturer for negligently designing a non-dangerous consumer product."[89] The motion judge went on to conclude that, even if such a claim were recognized in Canadian law, there were overriding policy considerations that negated a duty of care.[90] It was thus plain and obvious that the pleading did not disclose a cause of action and thus the class action could not proceed.[91]

On appeal, the plaintiffs argued that the motion judge erred in concluding that Canadian law did not recognize a claim for economic loss for negligent design of a non-dangerous consumer product and in conducting a duty of care policy analysis at a preliminary stage without a full evidentiary record.[92]

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[82] 2012 ONSC 4642 (Can.).

[83] Arora v. Whirlpool Canada LP, 2013 ONCA 657 (Can.).

[84] *Id*. at para 4.

[85] *Id*. at para 5.

[86] *Id*. at para 6.

[87] *Id*.

[88] [1995] 1 S.C.R. 85, para. 12 (Can).

[89] 2012 ONSC 4642, para. 202 (Can.).

[90] *See id*. at paras. 280-96.

[91] *Id.* at paras. 202-04. The court reached the same conclusion as to the plaintiffs' remaining causes of action for negligent failure to warn, breach of warranty, and misrepresentation contrary to the Competition Act. *Id.* at paras. 100, 302.

[92] 2013 ONCA 657, paras. 69-70.

The Court of Appeal dismissed the appeal, noting that, to date, Canadian courts have limited tort recovery for economic loss absent physical harm or property damage. Although acknowledging that the Supreme Court of Canada had not settled the question whether recovery is permitted for pure economic loss where goods are shoddy, but not dangerous,[93] the Court of Appeal upheld the motion judge's finding that it was plain and obvious that policy considerations negated recognizing such a cause of action.[94] The court further held that the policy issues were appropriate to consider on certification because, on the facts pleaded in the case, a full factual record would not likely have been of assistance.[95] The decision in *Arora* brings the law in Ontario in line with the law in British Columbia set out in *M. Hasegawa & Co. v. Pepsi Bottling Group (Canada), Co*.[96]

B. *Canadian Law Does Not Generally Recognize Strict Liability*

There is no strict liability for unintended and nonnegligent harm in the common law provinces in Canada, with one exception not relevant to drug and medical device litigation.[97] Therefore, plaintiffs must plead and prove negligence in order to recover on a tort claim.

C. *Canadian Damage Awards are Typically Lower than in the United States*

1. Cap on Noneconomic Damages

Damage awards in Canada can be considerably lower than awards in the U.S. for similar cases. Among other reasons, there is a cap in Canada on the nonpecuniary (noneconomic) component of compensatory damages (i.e., pain and suffering), which is presently about $340,000 for the most catastrophic cases.[98] Moreover, the threshold for personal injury in Canada requires manifest physical injury or a "recognizable psychiatric illness."[99]

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[93] *Id.* at paras. 80, 83.

[94] *Id.* at para. 116.

[95] *Id*. at para. 91.

[96] 2002 BCCA 324, para. 3 (Can.).

[97] *See, e.g.*, Anderson v. St. Jude Med., Inc., 2012 ONSC 3660 (Can.); Schick v. Boehringer Ingelheim (Canada) Ltd., 2011 ONSC 1942 (Can.).

[98] This cap originated in a trilogy of cases decided by the Supreme Court of Canada in 1978: Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229 (Can.); Arnold v. Teno, [1978] 2 S.C.R. 287 (Can.); and Thornton v. School Dist. No. 57 (Prince George), [1978] 2 S.C.R. 267 (Can.). Originally $100,000, the cap has been adjusted for inflation and is now approximately $340,000. *See* Clost v. Relkie, 2012 BSCS 1393, para. 437 (Can.).

[99] *See* Healey v. Lakeridge Health Corp., 2011 ONCA 55, paras. 39-62 (tracing development of requirement and rejecting claim that Supreme Court of Canada changed the standard in Mustapha v. Culligan of Canada Ltd., 2008 SCC 27 (Can.)).

2. Punitive Damages Rarely Awarded

Although the question of whether the defendants have engaged in conduct that would warrant punitive damages is often certified as a common issue in common law provinces, recovery of substantive punitive damage awards is extremely rare in Canada. Indeed, the author has been unable to find any case in which punitive damages were awarded after trial in any case regarding a drug or medical device, whether an individual or class action.

Conclusion

Canadian courts will take a broad approach to jurisdiction over foreign defendants and will generally take territorial competence where it is alleged the defendant carries on business in the province, a tort was committed in the province, a contract connected with the dispute was made in the province, or the proceeding concerns restitutionary obligations that arose in the province. In such circumstances, the presumption of territorial competence is likely to be determinative in most cases.

Once the jurisdictional issues are determined, the foreign defendant in a class proceeding will face a low threshold for certification. An adequately pleaded cause of action and evidence of "some basis in fact" for each of the other certification criteria is sufficient for a putative class action to be certified. Indeed, class actions regarding drugs and medical devices have historically been routinely, almost invariably, certified in Canada, despite the complexity of such actions. In light of the recent decisions of the Supreme Court of Canada, it is anticipated that an increasing number of cases will be certified.

Recent Appellate Decisions Reshape the Landscape of Arbitration Law†

Stephen D. Feldman
Kelly Margolis Dagger

I.
Introduction

For in-house counsel who draft and enforce arbitration agreements, trying to keep up with the fast-moving landscape of arbitration law is a significant challenge. Over the last several years, the United States Supreme Court has issued three major decisions that affect the enforceability of arbitration agreements. State and federal appellate courts have then applied those decisions in varying ways. This article examines the key rulings and concepts in these seminal Supreme Court decisions.

† Submitted by the authors on behalf of the FDCC Appellate Law Section.

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II.
The FAA and Key Defenses to Enforceability of Arbitration Agreements

When it passed the Federal Arbitration ("FAA"),[1] Congress declared a "liberal federal policy favoring arbitration agreements."[2] Consistent with that policy, section 2 of the FAA provides that written agreements to arbitrate disputes in contracts involving transactions in interstate commerce "shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract."[3] In other words, when the FAA applies to an arbitration agreement, the agreement will be enforced unless a generally applicable contract defense precludes enforcement. For example, an arbitration agreement induced by fraud or duress is unenforceable.[4]

The Supreme Court's recent decisions on arbitration have focused on two often-overlapping defenses to enforceability asserted by the party seeking to avoid arbitration—typically the plaintiff—in response to a motion to compel arbitration.

The first defense is that arbitration is *prohibitively expensive*. The plaintiff who invokes this defense argues that the cost of arbitration—including filing fees and administrative costs, arbitrator's fees, witness fees, attorney fees, and any other costs—exceeds the amount that could be recovered in the arbitration.

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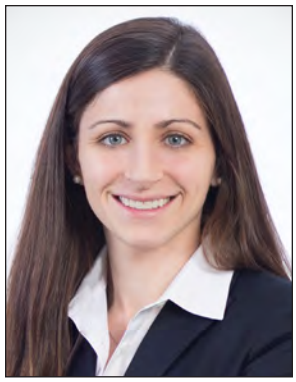
[1] Federal Arbitration Act, 9 U.S.C. §§ 1-16 (2014).

[2] Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 24 (1983).

[3] 9 U.S.C. § 2 (2014).

[4] Doctor's Assocs., Inc. v. Casarotto, 517 U.S. 681, 687 (1996).



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The second defense concerns *class action waivers*. Increasingly, arbitration agreements explicitly provide that the parties waive any right to pursue potential class action claims, meaning that a potential plaintiff may assert only individual claims in arbitration. Class action (or class arbitration) waivers prevent plaintiffs from sharing costs, such as attorney and witness fees, with other similarly situated plaintiffs.

To avoid the effect of such waivers, plaintiffs have invoked various state-law doctrines to argue that the waivers are invalid and render the arbitration agreement itself unenforceable. For example, many plaintiffs have argued that arbitration agreements containing such provisions are unconscionable because they effectively preclude litigation of low-value claims; i.e., no rational plaintiff would bring a claim in arbitration when the cost of pursuing the claim individually would exceed any potential recovery.

Recently, the Supreme Court may have foreclosed this argument. In particular, and as discussed more fully below, the Court has held that when a state law would invalidate an arbitration agreement because the agreement contains a class action waiver, that state law is likely preempted by the FAA—even if the result is that no rational plaintiff would bring an individual claim in arbitration. According to the Court, this result, though harsh, is mandated by the policies underlying the FAA.

A. *The Effective-Vindication Defense*

A starting point to understanding the Supreme Court's recent arbitration decisions is the 1985 decision in *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*[5] In that case, the Supreme Court considered whether a party could avoid arbitration of a federal statutory claim because the parties' arbitration agreement did not specifically mention that type of

[5] 473 U.S. 614 (1985).

claim.[6] The Supreme Court held that arbitration was required.[7] The key question, the Court noted, was whether the party could effectively vindicate its federal statutory cause of action in arbitration.[8] If the answer is yes, then the party could not avoid arbitration merely by asserting a federal statutory claim.[9]

In 2000, in *Green Tree Financial Corp.-Alabama v. Randolph*,[10] the Supreme Court revisited these concepts and more expressly acknowledged an effective-vindication defense. That defense has potency, the Supreme Court explained, when "the existence of large arbitration costs could preclude a litigant . . . from effectively vindicating her federal statutory rights in the arbitral forum."[11] The Supreme Court tasked the party asserting the defense—that is, the party seeking to avoid arbitration—with showing that the costs the party will incur in arbitration will exceed any likely recovery.[12]

Read together, the *Mitsubishi Motors* and *Green Tree* decisions appeared to permit a party alleging a federal statutory claim to use an effective-vindication defense to avoid arbitration. In *Green Tree* in particular, the Supreme Court explained that an effective-vindication defense could reconcile competing congressional policies: (1) the FAA's policy in favor of arbitration, and (2) policies in other federal statutes that favor judicial resolution of certain claims.[13]

Following *Green Tree*, many state appellate courts imported the Supreme Court's effective-vindication analysis when evaluating the enforceability of arbitration agreements under state law. These courts applied this analysis even when the plaintiff did not assert federal statutory claims.[14] Other courts tied the effective-vindication analysis to state law unconscionability standards, ruling that if a party could not effectively vindicate a state statutory claim in arbitration, the arbitration agreement was substantively unconscionable and, therefore, invalid.[15]

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[6] *See id*. at 624-25.

[7] *Id*. at 637.

[8] *Id*. at 636-37.

[9] *Id*.

[10] 531 U.S. 79 (2000).

[11] *Id*. at 90.

[12] *Id*. at 91.

[13] *See id*. at 90.

[14] *See, e.g.*, Tillman v. Commercial Credit Loans, Inc., 655 S.E.2d 362, 366 (N.C. 2008); Fiser v. Dell Computer Corp., 188 P.3d 1215, 1220-21 (N.M. 2008).

[15] *See, e.g.*, Schnuerle v. Insight Commc'ns Co., 376 S.W.3d 561, 573 (Ky. 2012); State *ex rel.* Richmond Am. Homes of W.Va., Inc. v. Sanders, 717 S.E.2d 909, 921 (W.Va. 2011); *Tillman*, 655 S.E.2d at 373; Vasquez-Lopez v. Beneficial Or., Inc., 152 P.3d 940, 952 (Or. Ct. App. 2007).

B. *Challenging Class Arbitration Waivers*

One way a plaintiff can cost-effectively pursue relief via arbitration is by arbitrating the claim on a class basis. According to defendants, however, the complexities inherent in class proceedings are fundamentally at odds with the core benefits of arbitration. In light of this tension, state courts applying the effective-vindication test were frequently called upon to adjudicate the availability of class proceedings in arbitration.

The Supreme Court addressed these arguments in *Stolt-Nielsen S.A. v. AnimalFeeds International Corp.*[16] In *Stolt-Nielsen*, the parties entered into an arbitration agreement that did not address the permissibility of class arbitration.[17] The Supreme Court held that the plaintiff could *not* pursue classwide relief in arbitration because the parties had not agreed to it.[18] The Supreme Court reasoned that, because of the degree to which class proceedings alter the arbitration process, it could not be assumed the parties consented to *class* arbitration simply because they agreed to arbitrate their disputes.[19]

One year later, in *AT&T Mobility LLC v. Concepcion*,[20] the Supreme Court again examined the circumstances in which a party can assert, or be barred from asserting, class claims in arbitration proceedings. *Concepcion* concerned a California state-law rule that effectively barred class action waivers in consumer contracts calling for arbitration. Under this rule, first announced by the California Supreme Court in *Discover Bank v. Superior Court*,[21] a class arbitration waiver was unconscionable—and therefore invalid—if the waiver was part of a "consumer contract of adhesion in a setting in which disputes between the contracting parties predictably involve small amount of damages."[22] In other words, if a consumer adhesion contract contained an arbitration agreement that included a class action waiver, and the arbitration clause was likely to cover low value claims, the California rule invalidated that agreement.[23]

AT&T argued that the so-called "*Discover Bank* rule" was preempted by the FAA. The Supreme Court agreed. A rule that requires classwide arbitration to be available, the Supreme Court said, "interferes with fundamental attributes of arbitration."[24] That interference cannot be reconciled with the FAA's liberal policy in favor of arbitration and thus "creates a scheme inconsistent with the FAA."[25]

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16 559 U.S. 662 (2010).

17 *Id*. at 684.

18 *Id*. at 686-87.

19 *Id*.

20 131 S. Ct. 1740 (2011).

21 30 Cal. Rptr. 3d 76, 87 (2005)

22 *Concepcion*, 131 S. Ct. at 1746 (quoting *Discover Bank*, 30 Cal. Rptr. 3d at 87).

23 *Id*.

24 *Id*. at 1748.

25 *Id*.

Notably, the Supreme Court in *Concepcion* had no sympathy for plaintiffs with small damages claims for whom a class action was the only cost-effective method for seeking redress of those claims. In the words of the *Concepcion* Court, even if "class proceedings are necessary to prosecute small-dollar claims that might otherwise slip through the legal system[,] . . . States cannot require a procedure that is inconsistent with the FAA."[26]

III.
The Fate of Class Arbitration Waivers in the Appellate Courts

Following *Concepcion*, state and federal appellate courts have struggled to determine exactly how to apply the Supreme Court's mandate. These post-*Concepcion* decisions can be divided into three categories: those that interpret the opinion narrowly, those that interpret it expansively, and those that strike a middle ground between the two extremes.

A. *Narrow Interpretations of Concepcion*

One group of appellate courts applying *Concepcion* has interpreted the FAA's preemptive scope narrowly. Under these decisions, the FAA preempts only state-law rules that mirror the *Discover Bank* rule—i.e., those that, in large part, *automatically* invalidate class arbitration waivers.[27]

For these courts, the FAA's preemptive effect turns on the nature of the state-law rule used to evaluate the validity of a class action waiver.[28] If that state-law rule is more flexible than the *Discover Bank* rule, then the FAA does not preempt that rule. And if the state-law rule is not preempted, that rule—such as unconscionability—can be used as a framework to demonstrate that an arbitration agreement with a class action waiver is invalid.[29] In that circumstance, a plaintiff may avoid arbitration by showing that he or she cannot effectively vindicate his or her rights, even for state-law claims, because of the cost of individual arbitration.[30]

B. *Expansive Interpretations of Concepcion*

Another group of appellate courts has taken the polar opposite approach. These courts have concluded that, under *Concepcion*, the FAA preempts *any* consideration of class

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[26] *Id*.

[27] *See* Kelker v. Geneva-Roth Ventures, Inc., 303 P.3d 777, 780-82 (Mont. 2013); Brewer v. Mo. Title Loans, 364 S.W.3d 486, 491 (Mo. 2012).

[28] *See Brewer*, 364 S.W.3d at 491 (interpreting *Concepcion* as allowing "case-by-case approach" to class action waivers).

[29] *See id.* at 493-96.

[30] *Id*.

arbitration waivers by any state-law rule used to evaluate the enforceability of an arbitration agreement.[31]

In view of these courts' broad interpretation of *Concepcion*, plaintiffs in these jurisdictions are hard-pressed to argue that an arbitration agreement is invalid because a class action waiver renders arbitration cost-prohibitive.[32] One of these courts, however, has suggested that an effective-vindication claim based on the high cost of arbitration might remain viable if the plaintiff can establish that arbitration fees themselves are prohibitively high, or that the location of the arbitration is exceptionally remote.[33]

C. *Decisions Adopting a Middle Ground*

A third group of appellate courts falls within the two extremes. These courts hold that the FAA preempts even flexible state-law rules, like unconscionability, that invalidate arbitration agreements with class action waivers. However, they do not wholly foreclose a party from pointing to the effects of a class action waiver as a consideration in analyzing an effective-vindication defense.[34] Such an approach is viable in light of the fact that *Concepcion* did not specifically address, much less invalidate, the effective-vindication defense enunciated in *Mitsubishi Motors* and *Green Tree*.

For example, in *Cottonwood Financial, Ltd. v. Estes*,[35] the Court of Appeals of Wisconsin upheld an arbitration agreement containing a class arbitration waiver.[36] According to the *Cottonwood* court, *Concepcion* means only that "the FAA preempts any state law that classifies an arbitration agreement as unconscionable . . . simply because the agreement prohibits an individual from proceeding as a member of a class."[37] The court did not address whether, after *Concepcion*, courts were still permitted to take into account the effects of a class action waiver on a case-by-case basis.

Likewise, the Court of Appeals of Ohio enforced an arbitration agreement with a class action waiver, but did not address whether such a waiver could ever cut against enforcement of an arbitration agreement.[38] The West Virginia Supreme Court has also left this question open.[39]

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[31] *See* McKenzie Check Advance of Fla., LLC v. Betts, 112 So. 3d 1176, 1187 (Fla. 2013); Coneff v. AT&T Corp., 673 F.3d 1155 (9th Cir. 2012); Cruz v. Cingular Wireless, LLC, 648 F.3d 1205, 1212 (11th Cir. 2011); Schnuerle v. Insight Commc'ns Co., 376 S.W.3d 561, 572 (Ky. 2012).

[32] *See, e.g.*, *McKenzie*, 112 So. 3d at 1187.

[33] *Schnuerle*, 376 S.W.3d at 573.

[34] *See, e.g.*, Muriithi v. Shuttle Express, Inc., 712 F.3d 173, 180-81 (4th Cir. 2013).

[35] 810 N.W.2d 852 (Wis. Ct. App. 2012).

[36] *Id*. at 858.

[37] *Id*.

[38] Wallace v. Ganley Auto Grp., No. 95081, 2011 WL 2434093, at *6-7 (Ohio Ct. App. June 16, 2011).

[39] State *ex rel.* Richmond Am. Homes of W.Va., Inc. v. Sanders, 717 S.E.2d 909, 920 (W.Va. 2011).

IV.
"Effective Vindication" in the Context of Class action Waivers

These decisions set the stage for the Supreme Court's June 2013 decision in *American Express Co. v. Italian Colors Restaurant* ("*AmEx III*").[40] In *AmEx III*, a restaurant argued that its arbitration agreement with American Express was invalid because it included a class action waiver.[41] More specifically, the restaurant said that the costs of proving its claims in individual, rather than class, arbitration would be too high to allow the restaurant to vindicate its rights under the Sherman Act.[42] On three separate occasions, the Second Circuit agreed, holding that the plaintiffs had made a sufficient showing of prohibitive costs to avoid arbitration.[43] In the court's view, because *Concepcion* did not alter *Green Tree*, the effective-vindication defense remained viable.

The Supreme Court disagreed. The effective-vindication defense, the Court explained, prevents a party from prospectively waiving its "right to pursue" statutory remedies.[44] The *right to pursue* a statutory remedy, however, does not guarantee a *cost-effective pursuit*. In the Court's words, "the fact that it is not worth the expense involved in *proving* a statutory remedy does not constitute the elimination of the *right to pursue* that remedy."[45] The *AmEx III* decision thus prevents a party from avoiding arbitration based on the financial impracticality of pursuing a complex small-dollar claim in individual arbitration.

Although precluding assertion of an effective-vindication defense based solely on the existence of a class arbitration waiver, the *Amex III* decision did leave some room for asserting such a defense. The effective-vindication exception, the Supreme Court explained, would apply to an arbitration agreement that forbids the assertion of certain statutory rights.[46] Large filing and administrative fees, too, could justify an effective-vindication defense.[47]

Justice Kagan wrote a stinging dissent. She called the decision "a betrayal of our precedents."[48] Pointing to *Mitsubishi Motors* and *Green Tree*, the dissent argued that the effective-vindication rule serves "to prevent arbitration clauses from choking off a plaintiff's ability to enforce congressionally-created rights."[49] Moreover, the dissent explained, the

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40 133 S. Ct. 2304 (2013).

41 *Id*. at 2308.

42 *Id*.

43 *Id*.

44 *Id*. at 2310 (quoting *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 637) (emphasis in original).

45 *Id*. (emphasis in original).

46 *Id.*

47 *Id*. at 2311.

48 *Id*. at 2313 (Kagan, J., dissenting).

49 *Id.*

federal policy favoring arbitration is a policy that favors the *method* of dispute resolution, not the killing off of valid claims.[50] Consistent with this policy, the effective-vindication rule ensures that arbitration is a real, viable method of dispute resolution.[51] Without the effective-vindication rule, "companies have every incentive to draft their agreements to extract backdoor waivers of statutory rights, making arbitration unavailable or pointless."[52]

V.
Enforcing Class Arbitration Waivers After *AmEx III*

The *AmEx III* decision leaves open several important questions for parties seeking to enforce arbitration agreements containing class action waivers.

For example, courts have continued to recognize that the FAA, like any federal statute, may be "overridden by a 'contrary congressional command.'"[53] Litigants have argued—so far, with little success—that such a contrary congressional command exists when a federal statute includes a collective action provision.[54] However, the Eleventh Circuit's analysis in *Walthour v. Chipio Windshield Repair, LLC*, suggests the effective-vindication analysis may have continuing relevance in determining whether a federal statute contains a contrary congressional command sufficient to invalidate an arbitration agreement containing a class action waiver.[55] In *Walthour*, the plaintiffs and their employers signed arbitration agreements with class action waivers.[56] The plaintiffs brought a putative collective action against their employers alleging violations of the Fair Labor Standards Act ("FLSA").[57] When the defendants moved to compel arbitration, the plaintiffs argued they could not be required to arbitrate their FLSA claims individually because the FLSA specifically permits collective actions, and the collective action provision thus constituted a "contrary congressional command."[58] Although the Eleventh Circuit disagreed, it did so only after analyzing whether Congress viewed collective actions as essential to the effective vindication of an FLSA claim.[59]

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[50] *Id.* at 2315.

[51] *Id.*

[52] *Id.*

[53] Walthour v. Chipio Windshield Repair, LLC, 745 F.3d 1326, 1330 (11th Cir. 2014) (quoting Shearson/Am. Express, Inc. v. McMahon, 482 U.S. 220, 226 (1987)); *see Amex III*, 133 S. Ct. at 2309.

[54] *Walthour*, 745 F.3d at 1330.

[55] *See id*. at 1335.

[56] *Id*. at 1328.

[57] *Id.* at 1329.

[58] *Id.* at 1330.

[59] *Id*. at 1334-35 (holding that legislative history did not show congressional intent for collective action to be essential to effective vindication of FLSA claims).

Nor is it clear how the Court's reasoning in *AmEx III* will affect state law unconscionability doctrine. The state appellate courts that have adopted some version of the effective-vindication defense—and that have imported that analysis into state law rules of substantive unconscionability—may choose to limit the effect of *AmEx III* by characterizing it as a decision of federal common law concerning only the arbitrability of federal statutory causes of actions.

To the same end, state courts that have interpreted *Concepcion* to allow consideration of the effects of class action waivers as part of a case-by-case unconscionability analysis might simply continue to apply that analysis, effectively limiting *AmEx III*'s definition of "effective vindication" to federal statutory rights. Whether that approach will succeed, however, is open to serious question: The Tenth Circuit, at least, has made clear that state courts cannot use that approach to avoid the FAA.[60]

Some state courts that have continued to consider the effects of class action waivers after *Concepcion* might reverse course in light of *AmEx III*. For example, prior to *AmEx III*, the Supreme Judicial Court of Massachusetts had interpreted *Concepcion* to permit an arbitration agreement with a class action waiver to be invalidated on unconscionability grounds if the plaintiff demonstrated that individual arbitration would be cost-prohibitive.[61] More recently, however, the same court recognized that *AmEx III* abrogated that interpretation of *Concepcion*; thus, cost-prohibitiveness, even when analyzed in terms of unconscionability, is not a defense to an individual arbitration agreement.[62]

Courts that have held that the FAA's preemptive effect is limited to state-law rules of automatic invalidation, like California's *Discover Bank* rule, may quickly find themselves in the minority. Indeed, the California Supreme Court itself recently held that *Concepcion* "invalidated our decision in *Discover Bank*" and stated that the fact that a "rule against class waiver[s] is stated more narrowly than *Discover Bank*'s rule does not save it from FAA preemption under *Concepcion*."[63]

Courts that have not yet addressed the import of *Concepcion* will now have the benefit of the Supreme Court's emphatic reaffirmance of *Concepcion* in *AmEx III*. Considering the two decisions together, state appellate courts may be more likely to interpret the preemptive impact of the FAA broadly. For example, prior to *Concepcion* and *AmEx III*, the North

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[60] THI of N.M. at Hobbs Ctr., LLC v. Patton, 741 F.3d 1162, 1170 (10th Cir. 2014) ("[W]e cannot agree with the statement . . . that because the state court's invalidation of the ban on class relief rests on the doctrine of unconscionability, a doctrine that exists for the revocation of any contract, the FAA does not preempt [the state court's] holding." (Internal quotation marks omitted)).

[61] Feeney v. Dell Inc., 989 N.E.2d 439, 462 (Mass. 2013).

[62] Machado v. System4 LLC, 993 N.E.2d 332, 332 (Mass. 2013); *see also* Lewis v. Advance Am., Cash Advance Ctrs. of Ill., Inc., No. 13-cv-942-JPG-SCW, 2014 WL 47125, at *3 (S.D. Ill. Jan. 6, 2014) (holding FAA preempted application of state-law unconscionability doctrine to invalidate arbitration agreement based on cost-prohibitiveness).

[63] Iskanian v. CLS Transp. Los Angeles, LLC, 173 Cal. Rptr. 3d 289, 295, 296 (2014).

Carolina Supreme Court had adopted the cost-prohibitiveness principle of *Green Tree* as part of its state-law unconscionability analysis for class action waivers.[64] Recently, however, an intermediate appellate court in North Carolina squarely rejected that analysis, holding that after *Concepcion* and *AmEx III*, whether individual arbitration is cost-prohibitive is no longer relevant to unconscionability under state law.[65]

One particular area of interest for state appellate courts might be the statement in *AmEx III* that the effective-vindication defense could invalidate "an arbitration agreement forbidding the assertion of certain statutory rights."[66] This statement provides a pulse—even if a weak one—to effective-vindication analyses that have bled into state-law unconscionability doctrines. Conceivably, an arbitration agreement that purports to prohibit the assertion of remedial statutory rights, such as the recovery of attorney fees or double or treble damages, could still be invalidated on effective-vindication grounds.

VI.
Conclusion:
A Word for Drafters

It is difficult to predict how arbitration law will continue to evolve after *AmEx III*. Nonetheless, it is clear that attorneys charged with drafting arbitration clauses should avoid any provision that could be perceived as a prospective waiver of statutory rights. Another party might enthusiastically agree to give up a particular statutory right in exchange for a better bargain in other respects; however attractive that waiver might seem, it could be costly if it results in invalidating an arbitration agreement.

Drafters should also keep in mind that *AmEx III* did not end all cost-based challenges to arbitration agreements. For example, the Supreme Court suggested that an arbitration agreement that requires the claimant to pay "filing and administrative fees attached to arbitration that are so high as to make access to the forum impracticable" might be considered an impermissible waiver of the right to pursue a statutory claim.[67] The Court did not elaborate on how lower courts should evaluate whether arbitration fees render the forum impracticable. The Ninth Circuit has weighed in on this question, holding that an arbitration agreement with a cost-sharing provision that required a claimant to pay significant arbitration costs up front—an amount the court determined would "likely dwarf[ ] the amount of [the plaintiff's]

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[64] Tillman v. Commercial Credit Loans, Inc., 655 S.E.2d 362, 366 (N.C. 2008).

[65] Torrence v. Nationwide Budget Fin., 753 S.E.2d 802, 811 (N.C. Ct. App. 2014).

[66] Am. Express Co. v. Italian Colors Rest., 133 S. Ct. 2304, 2310 (2013).

[67] *Id*. at 2310-11.

claims"—was unconscionable under California law.[68] Rejecting a challenge made on the same grounds, a New Jersey federal court held that the plaintiffs' ability to pursue their statutory remedies through arbitration "would *not* be hindered" where the evidence established that the defendant had a policy and practice of paying for arbitral costs when its customers sought individual arbitration.[69]

As these authorities suggest, to avoid cost-based challenges, drafters might consider including a fee-shifting provision that forgives the individual claimant's filing fees and related administrative costs. While agreeing to pay such expenses might appear to encourage the filing of claims, that risk might be outweighed by a greater benefit: stopping a plaintiff from pursuing a cost-prohibitiveness defense. In the long run, arbitration filing fees might be a small price to pay to avoid time-consuming and costly litigation over the enforceability of the arbitration agreement.

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[68] Chavarria v. Ralphs Grocery Co., 733 F.3d 916, 925-27 (9th Cir. 2013). According to the court's estimate, plaintiff would have been required to pay $3,500 to $7,000 per day for the arbitrator's fee alone. *Id.* at 925.

[69] In re Sprint Premium Data Plan Mktg. & Sales Practices Litig., No. 11-2308 (SDW) (MCA), 2014 WL 685297, at *4 (D.N.J. Jan. 15, 2014) (emphasis added).

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